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FUNCTIONAL NERVE DISEASE

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FUNCTIONAL NERVE DISEASE

An Epitome of War Experience for the Practitioner

EDITED BY

H. CRICHTON MILLER, M.A., M.D.

Formerly Medical Officer in charge Functional Cases, No. 21 General Hospital,
Alexandria. Late Consulting Neurologist, 4th London General Hospital

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P R E F A C E

THE object of this volume is to present to the medical practitioner a simple and concise picture of the functional neuroses of war-time in such a manner that he may be able to apprehend the outstanding lessons taught by the experience of the Great War in this department of medicine.

The almost universal misuse of the term "shell-shock" has led to a widespread belief that the functional nervous disorders of war-time are due to high-explosive and other agencies not germane to civil practice. While not excluding the special effect of shell-concussion, it must be borne in upon public and practitioner alike that the vast majority of these disorders are due to agencies, mental and physical, which have their counterpart in every walk of civilian life. The problem confronting those who have been called upon to treat soldiers suffering from functional disorders is that which confronts every physician, sooner or later, seldom or often, in his private practice. As with every other class of case, its successful treatment primarily demands intelligent investigation. In the past this has been seldom devoted to it, mainly because, in the training of medical students, cases of this kind have been passed over in silence. It is to be hoped that one of the fruits of our war experiences will be to stimulate in all sections of the profession a new interest in the ætiology and treatment of functional cases.

Each chapter of this volume has been written by a medical officer who has had experience in treating war-

neuroses. While in the main their points of view are identical, there will necessarily be divergencies, repetitions, and even apparent contradictions. The reader must make allowance for these, remembering that modern psychopathology is of very recent growth, and that, as soon as we pass from the tangible to the intangible in disease, we must recognize the presence of the personal factor both in the patient and in the physician.

The ordinary medical man must have been completely bewildered in hearing of "shell-shock" treated by electricity, massage, psycho-analysis, discipline, and sympathy. This volume should help him to realize the appropriate place of each form of treatment, according to the exact nature of the case. He will no doubt understand, by the time he reaches the end of the book, that a vast amount of disappointment in treating these cases has resulted from the application of one form or another of treatment to cases of different types, without adequate individual diagnosis. In all departments of therapeutics we find panacea-mongers, and in this as in other departments the panacea-monger brings his own favourite method of treatment into disrepute, both by an undue insistence on its merits, and by its indiscriminate application in practice.

Medical opinion during the war has, generally speaking, passed through three stages with regard to this question. At first treatment was largely dominated by the tradition of the Regular Army, and the usual prescription was rest, sometimes diversified by massage or electricity. In the second phase the value of suggestion became evident, the numerous disappointments following rest-cures having opened the minds of those in charge to appreciate the startling and often dramatic results of the suggestion method of treatment. Thus the way was paved for the third stage, in which it was recognized that a large number of cases treated by suggestion broke down in the firing-line, or even before the firing-line was reached; it was

then that the analytical method came seriously into vogue.

Yet it must not be imagined that analytical treatment is to be regarded as entirely superseding other methods. It must necessarily be a factor in the treatment of most cases, but the experience of the war has taught us that it may suitably be combined with suggestion and other agents, and that it is only the physician who has an unbiassed outlook on therapeutics who is in a position to adapt his methods to the individual needs of his patients.

H. C. M.

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THE PHYSICAL FACTOR

CHAPTER I

PHYSICAL ÆTIOLOGY

BY H. CRICHTON MILLER, M.A., M.D.

Formerly Medical Officer in charge Functional Cases, No. 21 General Hospital, Alexandria. Late Consulting Neurologist, 4th London General Hospital.

A CONTROVERSIAL THEME.

The Opposing Theories.

1. Explanation of all morbid phenomena in terms of matter.
2. Cure of all neuroses by psychical procedure—Materialist, excluding emotion, unscientific—Psychotherapist, ignoring physical factors, obscurantist.

Their Co-ordination.

Relation and interaction of physical and psychical—Both considerations necessary to complete view of case.

Illustrations of Separator Diagnosis.

EMOTIONAL CONFLICT AND OBJECTIVE SYMPTOMS.

Physical reaction modified by existing mental state.

Theory Illustrated.

1. Syndrome of D.A.H.—Failure to discover conclusive physical cause, presupposes psychical origin—Extent of direct or indirect emotional control on cardio-vascular system unknown, but psychic ætiology of D.A.H. frequently proved.
2. Diarrhoea and asthma—Symptoms susceptible to emotional conditions, though mechanism may be subconscious.

PHYSICAL CONDITIONS INFLUENCING MENTAL LIFE.

Shell-concussion generally supposed chief physical factor in war—Experience, however, has proved conflict of emotional strain preceding shell explosion frequently influenced shell-shock—Danger of psychoneuroses following concussion of purely physical origin.

The Connecting Media.

Two most intimate points of contact : (1) blood-supply, (2) internal secretion—These are also two channels peculiarly sensitive to systemic intoxication—Emotions may affect mental stability : (1) directly, (2) indirectly, through endocrines to circulation—Sepsis may affect mental stability : (1) through circulation, (2) through endocrines to circulation.

FUNCTIONAL Nervous Disease has been the battle-ground of the great conflict between the scientists who attempt to explain all morbid phenomena in terms of matter, and those of the opposite school who endeavour to cure the neuroses by psychical procedure. The conflict was due to ignorance on both sides, and this ignorance, unfortunately, is by no means dispelled even yet ; but we are now able to see more clearly than before the relations between mind and body, the methods in which matter is influenced by thought, and the agencies through which emotion produces physical phenomena.

Having reached this point, it is no longer excusable to regard the problem of the psychoneuroses from any angle except that of the strict interactionist. The materialist who excludes emotion from his view of functional disease is not scientific ; he is merely out of date. The psychotherapist who ignores the physical factors must, in spite of frequent and dramatic successes, be classed as an obscurantist. The physician who has been trained to regard disease solely from the organic point of view, and the psychotherapist who has become accustomed to think exclusively in terms of mind, are both employing only monocular vision. Oculists are frequently obliged to explain to a patient that, whereas he has believed himself to be seeing with both eyes, he has really been using only one. There are in every branch of the medical profession men who believe that they study the neuroses "with both eyes," and they too are frequently mistaken. A considerable number of examples illustrating this point have come under my notice.

A sergeant labelled "Shell-shock" had been in hospital

for fourteen months. He was unable to walk more than the length of the ward, and that only with the aid of two sticks. He was receiving persistent massage and daily electric baths. The physician in charge was asked if there might not possibly be some psychical factor to be considered. The reply was that the man had been promised his discharge as soon as he could walk steadily, and that therefore the fear of returning to the front did not enter into the case. On further examination, however, it was found that this patient had strong reasons for believing that his wife was involved in an intrigue with another man, and his fear of returning home to face this painful situation was proved to be the primary factor in his condition.

A young man was discharged, as incurable, from one of the special institutions for the treatment of functional cases. According to his own account he had been treated by analysis for five months. He was awarded a pension based upon a hundred per cent. disability. His mouth was so completely septic that a reputable dentist said that the only possible way in which to deal with it was to extract every single tooth. When, six months after this advice had been carried out, he appeared for re-examination by the Board, he announced himself cured and gave every indication of being so.

A corporal in the Territorial Force was invalided home from India with the diagnosis of Exhaustion-psychosis from malaria and dysentery. He was admitted to an institution in which he was treated by hypnotic suggestion, but at the end of six months he had made scarcely any progress. The skin over his knuckles was of a dusky brown colour, his blood-pressure was under 90 mm.—in short, he was a clear case of hypo-adrenia, and reacted rapidly to the treatment for that condition.

Such examples of what may be termed "monocular diagnosis" could be multiplied indefinitely. It is therefore fitting that at the very outset we should recog-

nize the grave danger of losing sight of the physical factors.

Every physical reaction may be modified, however slightly, by the mental condition obtaining at the moment. It is true that in certain stolid and bovine types the somatic reaction is but little influenced by the concomitant emotional states, whereas those persons who are called, in popular phrase, "temperamental"—artists, geniuses, potential epileptics—exhibit a pronounced variation in reacting to physical stimuli under emotional conditions.

There is no better illustration of this than the syndrome usually described as D.A.H. Tachycardia in a psychasthenic who has no demonstrable cardiac lesion usually produces the following note on the man's case sheet: "Rapid heart-beat on the slightest exertion." From the point of view of symptomatology this is possibly an adequate description, but it is a totally inadequate one from the point of view of ætiology or efficient treatment. The physician has been unable to differentiate between physical and psychical causes. He may have examined the heart very carefully, and may be convinced that there is no valvular lesion, while such dilation of the ventricle as may be discernible is not to be regarded as a causative factor. It may be contended that the condition might be consequent upon hyperthyroidism or hypo-adrenia, but even if this be the case, what is the link antecedent to endocrine disequilibrium? Physical exercise, pure and simple, does not produce it; hypo-adrenia may conceivably be due to some toxæmic process, but hyperthyroidism is almost certainly caused by emotional strain.

The army doctor has had no opportunity of testing the effect of purely physical exertion in dealing with the symptom under discussion. So long as the patient is in the army, any examination by an officer implies an emotional factor; and, moreover, until he is finally dis-

charged from military service, every medical examination bears upon the possibility of future exposure to danger. Hence it follows that a vast number of cases, classified by the army authorities as "functional heart disease," are, from an ætiological point of view, not classified at all. Possibly all of them may depend upon endocrine disequilibrium, and some may contain a toxic factor, but many are undoubtedly of psychic origin.

In civil life the physician is in a far better position. He is able to sift out the physical from the psychical factors, if he cares to take the trouble of doing so. The following case serves to illustrate the point. A man aged thirty-two had been brought up as an invalid and was supposed to have a weak heart. He had been warned against overexertion by all the doctors whom he had consulted. He was thoroughly examined by a cardiologist, who reported that, though there was no definite lesion, the heart was weak and would always remain so. The psychical condition of the patient, however, was such as to encourage the belief, despite the adverse verdict of the specialist, that his circulatory trouble was not altogether independent of his mental state. He was encouraged to take a little more exercise each day, and after some weeks he was able to perform a certain piece of work (wood-sawing) with less obvious exertion than that of an able-bodied man who acted as the control. It was then suggested that he should climb a ladder and cut off a branch of a tree at a height of about fifteen feet from the ground. He went up very cautiously, but before he had put his saw to the branch he announced that he was almost breathless and thought it best to come down. Here, then, was an example of dyspnoea due to emotional causes which would, under most circumstances, have been attributed to physical ones. The soldier's life abounds in situations of this kind in which exertion and emotion are combined in such a way that the patient is credited with a defective cardio-vascular system, whereas

in point of fact it is the emotional control that is at fault. How far that emotional control works directly on the cardio-vascular system, and how far through the medium of the endocrines, it is impossible to say, but it can be stated confidently that in many of these cases of D.A.H. we can prove a psychic ætiology without being able to demonstrate any endocrine disequilibrium, while in other cases presenting cardiac irritability there is clear evidence of hyperthyroidism, hypo-adrenia, or both.

Another group of symptoms clearly susceptible to emotional conditions is that of diarrhœa. A man may have an attack of amœbic dysentery, from which, so far as the bacteriologist is concerned, he has recovered, yet he may continue to have several motions daily. Any medical officer who has dealt with cases from Gallipoli and Mesopotamia must have seen examples of this condition to which the fear of returning to the front was undoubtedly contributing, if, indeed, it was not entirely causing the persistence of the symptom.

Asthma has been another fruitful ground of discharge from service. It has been fairly common among the troops, not only in Flanders, but also in Salonika and in Egypt, and it is impossible to think that the respiratory disturbance was caused either by exertion or by climatic factors. The emotional factor has been only too obvious in many cases. In a hospital in Egypt I saw three asthmatics invalided from Mesopotamia, lying in beds next to each other. All had improved substantially when one day a Medical Board came and examined the patients on one side of the ward, passing some for England, and ordering others to convalescent camps. It was announced that the other side of the ward was to be examined on the following day. During that night the three asthmatics neither slept themselves, nor allowed anyone else in the ward to sleep, and next morning their condition was so pitiable that they were unhesitatingly passed for evacuation. Now these men were not malingerers. I am

certain that the mechanism in their case was subconscious ; nevertheless, the exacerbation of the asthma was due solely to emotional causes.

In civil life physicians are constantly confronted by such cases. If they are satisfied to deal with them by means of a stethoscope and a hypodermic syringe, they will unquestionably pass over the psychic factor which is never wholly absent from cases of asthma, and is very frequently the sole origin of the complaint. Here again it must be noted that the civilian practitioner is in a far better position than is the military medical officer for arriving at a true diagnosis, and therefore, if he is satisfied with a purely objective estimate of the disease, his failure is all the more culpable.

So far we have been dealing with the part played by emotional conflict in the production, maintenance, or exaggeration of objective symptoms. Let us now turn to the physical conditions influencing mental life.

We all have conflicts ; this volume is largely occupied with the question of their treatment. The soldier, in so far as personal danger is associated with his calling, has more serious conflicts to deal with than other people have. Some soldiers succeed in resolving their conflicts—that is to say, in adjusting their own desires and passions to reality ; others do not so succeed, and in consequence they develop a neurosis. At one end of the scale we have men so placid, so confident, so self-controlled, that they can stand long periods of trench warfare, constant contact with horrors and repeated exposure to terror, and yet remain so wholesome and sane that even a period of six months in hospital with a fractured femur leaves them normal. At the other end we have men whose conflict begins when their calling-up notice arrives, or even sooner, and who are so utterly incapable of making their own adjustments that they are recognized as psychoneurotics even by the recruiting officers. Again, somewhere in the scale there are men able to make their

own adjustments so long as they are organically fit and well, but whose power to resolve their conflicts ceases as soon as their bodily health falls below par.

It is generally supposed that the physical factor most largely concerned in the production of war neuroses is shell-concussion. I have grave doubts as to the accuracy of this belief; but it is to be regretted, on the other hand, that a certain school of psychotherapists has written as though the emotional factors were the only ones to be considered. Any physician who has taken the trouble to interrogate closely an extensive series of cases (as, for example, at the Special Medical Board of the Ministry of Pensions) must necessarily realize that there is only a relatively small number of cases of nervous disease in which the explosion of a single shell in the immediate vicinity of the patient was responsible for a sudden change from perfect health of mind and body to the state generally described as "shell-shock." In most cases the patient's self-assurance and self-control had been gradually deteriorating for weeks or even months before the moment at which he collapsed as the result of two or three narrow escapes from high explosives. Almost invariably the emotional factor of seeing his friends killed or mutilated was added to that of personal terror. Nevertheless, in a small proportion of cases a history would be obtained of a man who had been healthy, happy, and confident in the trenches up to the time when he was blown up by a high-explosive shell and rendered unconscious until he found himself in the dressing-station. In such a case we are compelled to recognize that the causative factor is physical, and we therefore ask ourselves: "What is the nature of this shock?"

Let us first of all realize that it differs intrinsically from an ordinary concussion. The physical process in true shell-shock has nothing in common with the shock which occurs when a motor-cyclist is thrown from his machine on to his head. It has nothing in common with, in fact

it is the reverse of, surgical shock, as, for instance, when a soldier has had both legs blown off, is carried off to the casualty clearing-station and undergoes a double amputation, dying immediately afterwards. In this latter case the shock is caused by trauma to the peripheral nerves combined with cerebral ischæmia. The victim of true shell-shock has been subjected by the force of the explosion to a definite atmospheric pressure, encountering three zones of resistance: (1) the abdominal wall (which is, however, practically non-resistant); (2) the thorax; and (3) the cranium, where the resistance is complete. The tendency must therefore be for a displacement of content to occur from the abdomen to the thorax, and from the thorax to the cranium.* The nearest approach in civilian life to this physical effect is the unsuccessful dive. A man diving from a height and slipping as he "takes off" lands flat on the surface of the water: the concussion is more or less evenly distributed; the non-resistant abdominal wall protects the abdominal contents least, and the resistant cranium protects the brain most. Hence there must be displacement of content from abdomen to thorax, and from thorax to cranium, ending in a greatly increased intracranial pressure.

We may therefore conceive of the blood reaching the cerebral arteries in something resembling a tidal wave, and subjecting the arterioles to a process of distension so abnormal as to produce a temporary paresis. This conception enables us to understand those cases of genuine shell-shock in which no sort of treatment appears to do good except prolonged rest, and, further, the theory is supported by post-mortem evidence of punctate hæmorrhages in the brain and cord as described by Mott and other observers.

On this hypothesis it is reasonable to conclude that

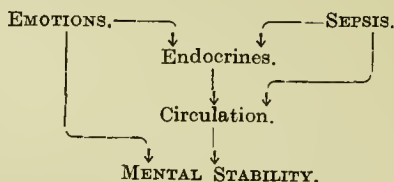
* It might be supposed that the lungs would be emptied of air, but we must remember that the air, endeavouring to escape by the upper respiratory passages, meets the general pressure of the explosion.

the purely concussive effects of a shell explosion would be felt less severely by the man with a perfect vascular system, and that any disturbance of this system, whether in the direction of hypertension or hypotension or of sclerosis, must necessarily accentuate those effects. All observers of war-time neuroses will agree that cases with pronounced vascular disequilibrium almost invariably offered a grave prognosis.*

Such cases of pure concussion of course present no psychical features in their ætiology. There are, however, two things to be remembered : (1) Cases of true shell-shock are, as I have already stated, very rare ; (2) when they do occur the physician treating them must see to it that during the period of the patient's disability he does not develop a genuine psychoneurosis based upon a conflict which is inseparable from such a condition of incapacity without obvious cause.

From what has been said before it is clear that the two points at which the physical comes into most intimate contact with the psychical are those of (a) blood-supply, (b) internal secretion. Now, it also happens that these are the two channels peculiarly sensitive to systemic intoxications. Hence it is to be expected that Functional Nervous Disease should be very frequently associated with a chronic toxæmia, either because the toxæmia produces a sclerosis and thereby influences the cerebral circulation, or because it adversely affects the functioning of the endocrine system.

We may therefore conceive of the main causative links in some such way as the following :



* It appears that other high explosives exposed to the effect of detona-

An emotion, for example fear, may produce a direct effect on mental stability, but it may also produce an effect on the endocrine system, notably by causing hyperthyroidism, which would lower the vascular tension, and the circulatory disturbance, in its turn, would react finally upon mental stability. A septic condition would act upon the endocrine system, for example, by causing hypo-adrenia; this would also lower the blood-pressure, and so once again a psychic effect would be produced; or a septic toxæmia might act directly upon the circulation by setting up arterio-sclerosis, thereby producing a condition of hyperpiesis, which would have a definite influence upon the mental life.

The subsequent chapters will contain far more conclusive material both on the physical and on the psychical side than is called for here, but it is hoped that enough has been said to impress upon the reader the conviction that generalizations about Functional Nervous Disease are worthless, and to prevent his losing sight of the psychical while dealing with the physical, or of the physical while dealing with the psychical.

tion at a distance which does not cause their own, are rendered permanently more sensitive and liable to accidental detonation unless they are handled with the utmost care. It has been suggested by Carver (at a meeting of the Section of Neurology, Royal Society of Medicine, March 13th, 1919) that this change is a molecular one due to vibrations which are a part of the explosion. He surmises that analogous molecular or biochemical changes may, under similar conditions, take place in the Central Nervous System.

CHAPTER II

DIFFERENTIAL DIAGNOSIS

BY GEORGE RIDDOCH, M.D., M.R.C.P.

Physician, Empire Hospital for Injuries to the Nervous System. Physician to Out-patients, Hospital for Paralysis and Epilepsy, Maida Vale. Consulting Neurologist, Queen Alexandra Military Hospital, Millbank, London.

STRUCTURE OF SCIENTIFIC DIAGNOSIS.

Reaction against exclusive study of morbid anatomy and histology to primary study of disordered function.

DISTURBANCES OF FUNCTION.

Search for : (1) general principles of underlying causative factors, (2) reactions to given conditions—Hughlings Jackson theory endorsed : Positive symptoms cannot be attributed to a negative lesion—Disordered function does not necessarily imply disordered structure—Symptoms, evidence of deranged function—Signs, evidence of gross structural change—Preventive value of symptom diagnosis—Significance of subjective phenomena—Profound influence of abnormal mental states on bodily functions and vice versa—Prime functions of nervous system, its integrative action—Consequent difficulty of separative diagnosis and treatment.

RELATION OF PSYCHICAL AND PHYSICAL.

Interrelation of emotion and endocrine and neural activities—Primary causative factor in neurosis may be : (1) psychogenic, (2) glandular disorders, (3) deleterious action of toxins, endogenous and exogenous—Primary causative factor in D.A.H. may be : (1) emotion, anxiety, (2) endocrine disturbances, (3) toxæmia, following dysentery, exposure to gas, etc.—Psychological methods necessary part of equipment for diagnosis—Difficulty of ascertaining extent to which functional defect, following structural damage to nervous system, is due to injury or psychogenic factors.

DIAGNOSES SUSCEPTIBLE OF CONFUSION.

1. *Disseminated Sclerosis and Neuroses.*

Possible confusion emphasizes necessity for systematic investigation of subjective phenomena—Numerous symptoms in common—Consequent importance of close neurological study for evidence of definite pathological changes—Symptoms suggestive of definite diagnosis.

2. *Concussion of Central Nervous System and Neuroses.*

The two conditions frequently occur together—Definite diagnosis essential to treatment—Suggestions for Diagnosis:—Physical: Lumbar puncture, discovery of blood in cerebro-spinal fluid in cases of concussion—Careful neurological examination may reveal evidence of cortical damage, meningeal hæmorrhage. Psychical: History of case of great value—Anamnesis may reveal growing neuroses—Headache symptom and uses of trephination.

PSYCHOLOGICAL FACTORS AND HEAD INJURIES.

Extent to which psychological factors increase functional defect.

1. *Cases with Considerable Loss of Bone.*

Complain of inability to adapt to ordinary conditions of life—Headaches, pulsation of scar, positive symptoms forming focus round which anxiety neuroses may develop—Closure of wound by osteoplastic graft, relieves headaches, obliterates pulsation, and so diminishes consciousness of physical disabilities—Psychological treatment, primary method of cure.

2. *Traumatic Epilepsy.*

Close association of faulty psychic processes and onset of disease—Consequent importance of ascertaining nature of these processes.

HEMIPLEGIA AND CONVERSION NEUROSES.

1. It may follow organic changes in brain.

2. It may be manifestation of hysteria—Gait distinctive in diagnosis—Study of voluntary movements reveals underlying inhibition in hysteric—During initial shock phase following injury to brain, muscles flaccid, then hypertonic—Rigidity may be temporarily overcome by massage—When hemiplegia psychic, period of flaccidity absent, muscles may be so rigid that passive movement is impossible—Abolition of abdominal reflexes, ankle clonus, and extensor plantar reflex diagnostic of organic condition—Response to cutaneous reflexes not infallible.

Extensor Plantar Reflex.

Reaction obtained when pyramidal system injured—It may, however, be present in: (1) severe disturbances of consciousness; (2) after epileptic fit—Explained by removal of control of higher over lower centres.

TILL recently it was commonly taught that the study of morbid anatomy and histology is the only firm basis on which the problems of disease can be investigated and an exact science of diagnosis built up. During the past fifteen years reaction against this teaching has set in and gained significant strength. The rarity of autopsies and the lack of interest in them in most military hospitals during the war would have been considered reprehensible a few years ago. The study of life and not of death is now attractive.

I

Interest is centred to-day in the investigation of disturbances of function, and therefore we are greedy for general principles. The study of isolated signs has lost interest for the growing school of medical research. Investigation as to whether the knee-jerk as a solitary phenomenon is present or absent no longer casts a glamour over us; we want to know what functional systems are out of order, and how the individual as a whole is reacting to altered conditions.

With this we are naturally beginning to believe what Hughlings Jackson taught for so long and with so little encouragement, that symptoms and signs are not produced by destroyed tissue, but are the expression of the mode of activity of what is left of the living organism. Positive symptoms cannot be attributed to a negative lesion.

Another truth that has been dawning on us is that disordered function does not necessarily imply disordered structure, but if it goes on long enough it may do so. In disease alteration of function precedes destruction of tissue, and it is manifest in the reactions not only of the organ or part most affected, but also in the individual as a whole. Broadly speaking, *symptoms are the evidence of deranged function, signs are the evidence of gross structural change.*

Therefore, with the ideal of preventive medicine before us, it behoves us in the future to investigate the diagnostic value of symptoms, a field almost entirely unexplored systematically, and to give signs a place of secondary importance, realizing that they are evidence of a more advanced and less curable stage in disease.

To understand symptoms we must listen to the patient. This proceeding may, perhaps, seem unnatural and irksome to many medical investigators, but it need no longer be so. The significance of subjective phenomena should be understood before we can hope to diagnose disease in its early stages.

The mass of evidence produced by the War has opened our eyes to the profound influence exerted by abnormal mental states on bodily function, and vice versa. We see more clearly that the prime function of the nervous system is its integrative action, and that its guiding and controlling force is the mind. Hence, as Payne and Jelliffe * emphasize, one of the most difficult distinctions to be made in diagnosis and in treatment is the separation of purely functional disorders only psychically conditioned from those due entirely to, or to a greater or less extent dependent upon, organic injury to the nervous system.

The following are illustrations of what is meant. A soldier received a bullet wound through the right upper arm. On examination at the base hospital it was found that the hand was paralysed, and there was complete loss of sensibility below the wrist. The humerus and the main blood-vessels were apparently uninjured. The question to be decided was, whether there was injury to the nerves which supply the muscles of sensation of the hand, or whether the condition was entirely or partly of psychic origin? The sensory loss did not correspond with the known distribution of the sensory nerves of the hand, and electrical examination of the muscles showed

* *The Journal of Nervous and Mental Diseases*, 1918, vol. xlvi, p. 248.

that all, except those supplied by the ulnar nerve, reacted normally to the faradic current. A faradic response was also absent in the flexor carpi ulnaris. The diagnosis of the functional loss was that it was due in part to failure of conduction in the ulnar nerve, the remainder being a manifestation of psychical disorder.

Another example may be given. A young soldier reported to his medical officer complaining of pain in the chest and legs. He was haggard from want of sleep, obviously worried and anxious, and thought that his heart was affected. Physical examination of the heart revealed no demonstrable signs of damage, and he responded to examination without abnormal increase in the rate of the heart-beat or of respiration. He was labelled as suffering from "neurasthenia." The diagnosis was correct, but not complete, for when the parts to which pain was referred were examined, hyperalgesia was made out in areas corresponding with the distribution of certain posterior spinal roots. The Wassermann blood test was positive. In this case the pain evoked by the irritative root lesions was the primary cause of the functional disturbance, the anxiety neurosis being secondary. It may be mentioned here that irritative root lesions of syphilitic origin are a not uncommon cause of pain referred to the trunk and limbs in young men.

It should be remembered that a neurosis may precede the onset of an organic condition, or may complicate it at any stage in its course.

The whole question of causalgia following median, ulnar and sciatic nerve lesions bristles with difficulties in diagnosis. When the pain has been established for some time and the patient is obviously in a neurotic condition, one may be unable to say how far the pain is an expression of the organic condition and how far it is psychogenic. The nerve may be divided or conduction blocked by the injection of alcohol and still too often the pain persists. What remains is the outcome, in part at least,

of faulty mental adjustment. At the same time, the possibility of alterations in the spinal cord being present cannot yet be eliminated.

II

Considerable attention has been directed in recent years, particularly in America, to the interrelation of emotion and endocrine and neural activities. The importance of this branch of study is beginning to be realized in this country. Neuroses may be primarily of psychogenic origin or due to disorder of the ductless glands. Here diagnosis offers the greatest difficulty.

Again, it is believed that abnormal mental states may be the outcome in the first instance of the deleterious action of toxins, endogenous or exogenous.

Of the group of men who were invalided with symptoms related to the functions of the heart, and labelled as having "disordered action of the heart" or "soldier's heart," a large number were found to be suffering from anxiety neuroses. Some physicians attributed the condition to mental stress and worry, others to endocrine disturbances, and others to toxæmia following dysentery, trench fever, or exposure to gas.

One of the lessons to be learned is the necessity for psychological methods as part of the equipment for diagnosis.

Again, though we can definitely say in a case that there is structural damage to the nervous system, and can localize the lesion, we are frequently unable to determine how far the functional defect is due to the injury and how far it is psychogenic. The following case is illustrative:

An officer was wounded in the back of the head by a shell fragment and the right occipital lobe was damaged. In the left half of his visual field there was a scotoma, larger for some visual stimuli than for others. A larger blind area was evident when the patient was tested for

the recognition of form than when he was tested for the appreciation of a stationary object, and this again than that for movement. More than a year after the date of the injury, when the healing process in the brain, with its consequent disturbance of function, must have ceased, the patient reported at hospital in a worried and depressed condition. His brother, who had been carrying on their business, was called up, and a few weeks later the manager was claimed by the Army and the patient was left to control affairs. He became sleepless, battle-dreams returned, headaches disturbed him once more, and his vision was getting worse. On charting his visual fields the scotoma was found to be larger, but the same dissociation in the affection of the different aspects of visual sensibility was evident. The psychical regression* had extended into the somatic sphere, and was there manifest, as a disturbance obeying physiological laws. The increase in his disability was then primarily due to a disorder of the mind, which, operating through his already disturbed cerebral function, increased the existing visual defect.

III

It is notoriously easy to confound disseminated sclerosis at an early stage with a neurosis. No subject more clearly demonstrates the necessity for systematic investigation of subjective phenomena. Psychology may again clear the path.

Both are most common in early adult life, and in both there is often a history of emotional shock with or without physical injury preceding the onset of the symptoms. Mental instability, facile emotionalism, vaguely described seizures, the complaint of peculiar sensations of numbness or tingling, sometimes at one part, sometimes at another, which come and go, all complicate the problem of diagnosis. The patient may for a short time lose some power

* See chapter on "Regression." Section C 2.

in one or both legs, the sight of one eye may be impaired and then mysteriously recover. There may have been some temporary difficulty in passing urine; articulation may be deliberate and scanning, and the arms tremble when moved voluntarily. All we can say at present is that a careful neurological examination, repeated at intervals, should be made, so that evidence of definite pathological changes may not be missed.

A diagnosis of disseminated sclerosis can be based on pallor of the optic nerve as revealed by ophthalmoscopic examination, nystagmus, intention tremor, squint, abolition of the abdominal reflexes (especially when there are no demonstrable sensory defects), an extensor plantar reflex obtained with stimuli of moderate intensity, and the abolition of one or both knee-jerks. These constitute signs of a multiple lesion.

In neurological base hospitals during the war, one of the fields of diagnosis in which the greatest difficulty has been encountered is the differentiation between neuroses, and concussion of the central nervous system. The two conditions frequently occur together, as can readily be imagined.

It was common to get a history that the man was brought to a field dressing-station in a dazed condition. He declared that he had been buried with earth thrown up by a shell and had been unconscious for some time. The problem to be solved was whether he was suffering from the effects of cerebral concussion alone, or from a neurosis, or both.

It is extremely important from the point of view of prognosis and treatment to be certain of the diagnosis, for if *commotio cerebri* is the pathological basis the patient will as a rule recover more quickly and more completely than if he is suffering from an anxiety neurosis, alone or associated with concussion. Further, the treatment of concussion of the brain is entirely different from that necessary in dealing with anxiety states. In the

first case rest, quiet, and ordinary hygienic conditions are all that is necessary for the majority of patients, whereas in the second psychotherapeutic treatment is essential.

How, then, can the diagnosis be made more certain? A few suggestions only can be given, as our knowledge at present is limited. Except during the first few days, when, by lumbar puncture, blood may be found in the cerebro-spinal fluid in cases of concussion, little help is forthcoming from examination of the body. Stress has been laid on alterations in the blood-pressure, with but slight justification, as an aid in differential diagnosis. At the same time each patient should, as a routine, be carefully examined neurologically, for, when the concussion has been severe, changes indicating cortical damage from fracture of the skull or meningeal hæmorrhage may be found.

Eliminating evidence of possible organic changes, the history is of the greatest value. If the anamnesis reveals that prior to the accident the patient had shown symptoms of regression, such as being more than usually disturbed by the bursting of shells and the whizzing of bullets, that he was irritable and depressed, or continually anxious in the performance of his duties, that he had difficulty in sleeping and was a prey to battle-dreams, there is evidence that his adaptation to the life he was leading was becoming imperfect.

The diagnostic value of battle-dreams as manifestations of commencing breakdown has been recognized. MacCurdy* lays stress on dipping of consciousness, confusion and disorientation as symptoms of organic disturbance of the brain.

The statement of the patient that he was unconscious for a period after the shell explosion should not be too readily accepted as accurate, though it is given in all good faith. For he is naturally unable as a rule to distin-

* *Psychiatric Bulletin*, 1917, vol. ii, p. 273.

guish between amnesia and loss of consciousness from physical injury.

Little can be said at the present time of the diagnostic value of headache as a symptom. As a subject for careful investigation it presents great possibilities. In a number of cases diagnosed as cerebral concussion, headache may persist for a prolonged period as a residual symptom, especially when there has been a scalp wound without fracture of the skull. A number of these cases have been trephined in the region of the wound, and local cerebral contusion has been found indicated by discoloration of the brain, with a thickened, opaque condition of the overlying arachnoid, which bulges through the opening made in the skull. The operation undoubtedly gives relief, but the cases in which it is to be performed should be carefully selected. The headache has its focus at the site of the injury and spreads from this point. It is a dull, steady ache persisting night and day, aggravated by exertion, and is the most prominent and perhaps the only disablement.

IV

The multitudes of patients incapacitated by injuries to the head present many problems, not only for the present, but for many years to come, and none are more difficult of solution than the estimation of how far psychological factors operate in increasing the functional defect. Two outstanding groups of cases may be mentioned: (1) those in which there is a considerable loss of bone; and (2) cases of traumatic epilepsy.

A large proportion of patients who have been wounded in the head complain of a definite series of mental symptoms which render them unable, quite apart from any disorder of bodily function associated with the brain injury, to adapt to ordinary conditions of life. They become most evident when the patients leave hospital and go out into the world again to struggle for a liveli-

hood. The degree of disability seems in many cases to be influenced by the size of the opening in the skull, being greater when the gap is large.

These patients suffer from headaches, which in some are most prominent during the day, and in others at night when they lie down. The scar, especially if the bone defect is extensive, usually pulsates freely on exertion and with excitement. These two positive symptoms never allow the patient to forget that his head is injured, and form a focus round which an anxiety neurosis can develop.

They are easily tired, both mentally and physically. It is a great strain for them to concentrate on anything, even for short periods. In consequence they forget easily, cannot assimilate ideas quickly, express themselves with difficulty, and lose faith in their ability to tackle any sort of work.

They soon become anxious and worried, sleep badly, and are troubled by unpleasant dreams, which often portray terrifying war scenes. They get up in the morning tired and listless, and a vicious circle begins.

To attribute the condition to physical fatigue and to prescribe rest and tonics only is obviously wrong, and may do a great deal of harm. For the patient is too keenly aware of his invalid state and of his inability to face the problems of life as he did before.

In many cases closure of the opening in the skull by an osteoplastic graft as the first stage in treatment is beneficial in relieving headaches that are due to traction on the sensitive dura mater, and in rendering the patient less conscious of his damaged head by obliterating the pulsation of the scar.

The subsequent treatment must largely be psychological, along the lines of helping the patient to readjust his outlook on the part he is now able to take in life necessitated by his altered mental and physical state.

The note played by mental conflict in the production of traumatic epilepsy, and in precipitating attacks, has

not been sufficiently recognized. Experience of epilepsy following cerebral injuries during the war has shown clearly that the site and nature of the lesion have little, if any, influence in determining the onset of fits. What is certain is the close association of faulty psychic processes with the onset of traumatic epilepsy, and no diagnosis is complete without ascertaining what these are. This is a field of research that requires long and careful study.

V

Hemiplegia may follow organic changes in the brain, or may be a manifestation of hysteria, or, as it is now widely called, conversion neurosis. Since the days of Charcot the differential diagnosis between the two clinical pictures has been much discussed, chiefly from the objective point of view, and with certain data present the problem is usually easy of solution.

If the patient can walk, the gait in the two conditions is distinctive. Whereas the hysteric drags the foot along the ground, the organic hemiplegic swings the extended limb forwards from the pelvis.

In testing the power of voluntary movement the underlying inhibition in hysteria becomes manifest, for the antagonistic muscles are involuntarily contracted, and the excessive effort made by the patient to move the part as requested portrays dramatically the dissociation that exists between conscious and unconscious activity.

During the initial shock phase which follows an injury to the brain, involving the pyramidal system, the paralysed muscles are flaccid. Their tone is diminished. Later, however, they become hypertonic, and the limbs assume the characteristic posture, the upper limb is flexed and the lower limb is extended. The rigidity can be overcome for the time being by massage.

When the hemiplegia is of psychical origin, however,

and the muscles are in a state of hypertonus, the rigidity may develop abruptly without a preceding phase of flaccidity, and, moreover, so tense may be the muscles that passive movement is impossible.

Abolition of the abdominal reflexes on the hemiplegic side, ankle clonus and an "extensor" plantar reflex are diagnostic of an organic condition. But it should be remembered that when hysterical hemiplegia is associated with hemi-anæsthesia, cutaneous reflexes may be elicited with difficulty or not at all on the affected side; and if the foot of an organic hemiplegic patient be cold, a response in the toes to plantar stimulation may be very difficult to obtain.

A word may be said here on the significance of the "extensor" plantar reflex. Normally when the sole of the foot is gently scratched the toes move down and adduct. This is called a "flexor" response. When, however, the pyramidal system is injured a different reaction is obtained. The response then evoked consists of contraction of the flexors of the hip and knee, of the dorsi-flexors of the foot and of the muscles which move the toes upwards. That is to say, the "extensor" plantar reflex occurs as part of a withdrawal or flexion-reflex of the limb as a whole. The limb, so to speak, retreats from harm.

Frequently the minimal response to stimulation is contraction of the hamstring muscles, and in consequence, when testing for the plantar reflex, the observer should palpate the tendons of these muscles as well as watch for movement of the toes.

Myers* mentions that an "extensor" plantar reflex has been obtained in cases of war neurosis where disturbance of consciousness was severe after burial. It is also the type of reaction often present after an epileptic fit.

The meaning of this mode of response in such cases can be understood when it is remembered that the flexion-

* Myers, *Lancet*, January 11, 1919.

reflex of the lower limb is one of the most primitive reflex reactions of the nervous system. It persists when the spinal cord has been completely divided, and is the normal reflex excited in the early months of childhood when the sole of the foot is tickled or pricked. In the adult it can be uncovered by removal of the control of higher over lower centres, as occurs in pyramidal disease, in loss of consciousness in general anæsthesia, in neural shock after severe cerebral concussion or an epileptic seizure, and probably after profound emotional trauma.

Nevertheless, in ordinary circumstances, the presence of an extensor plantar reflex, especially when associated with ankle clonus, exaggerated tendon jerks, and abolition of abdominal reflexes, establishes a diagnosis of interference with the functions of the pyramidal system.

In summarizing the salient points in the differential diagnosis of neurosis and organic nerve conditions, we would emphasize the necessity for careful investigation of all subjective symptoms and a routine neurological examination. In many cases only by psycho-analytical methods can a correct diagnosis be arrived at.

CHAPTER III

PHYSICAL TREATMENT

BY EDWIN BRAMWELL, M.D., F.R.C.P.Edin. and Lond.,
F.R.S.E.

*Physician to the Edinburgh Royal Infirmary. Lecturer on Clinical Medicine,
University of Edinburgh.*

SCOPE DEFINED.

"Physical . . . treatment of functional nervous disease comprises the therapeutic scope and mode of application of all remedial agents which do not necessarily act by a direct appeal to the mental faculties"—Difficulty of apportioning to psychical or physical action of remedy the benefit accruing from exhibition of physical procedure—Physical methods can be exploited for their psychical effect.

MODE OF APPLICATION.

Necessity of definite and comprehensive diagnoses—Patient's suggestibility carefully considered.

AGENCIES UTILIZED.

All physical agencies used for treatment of disease may serve.

Rest or Exercise.

Application dependent on psychical condition of individual.

Massage.

Invaluable for bed patients—Physical aid to circulation, nutrition, digestion—Psychical aid obtained by masseur's co-operation.

Electricity.

Its stimulating properties—Faradic current in treatment by persuasion and re-education of functional palsy—Avoidance of purely credulitive use.

Hydrotherapy.

Possible tonic effect, but benefit primarily due to change of surroundings and régime.

Diet.

Dietary concessions unnecessary except (1) in cases of marked loss of weight; (2) where gastro-intestinal symptoms conspicuous feature or cases with dyspeptic symptoms—Value of milk diet in rest cure.

Drugs.

Drugs play a subsidiary rôle—While of no specific curative effect in relation to neuroses, sometimes of undoubted service.

CONCLUSION.

Most physical symptoms in functional nervous disease demand psychotherapeutic care, and it is generally inadvisable to treat individual symptoms—Insomnia an exception to this rule.

THE physical as opposed to the psychical treatment of Functional Nervous Disease comprises the therapeutic scope and mode of application of all remedial agents which do not necessarily act by a direct appeal to the mental faculties.

An emotional factor plays an essential rôle in the production of the majority of the neuroses, consequently psychotherapy is primarily demanded in the treatment of these disorders. It is none the less true, however, that physical methods may be valuable and necessary adjuvants in the treatment of coexisting or secondary physical disturbances. In this connection it is to be remembered that it is often difficult or impossible to apportion to the psychical or physical action of the remedy the benefit which accrues from the exhibition of a physical procedure; while, further, it is to be borne in mind that physical measures may be exploited on account of the psychical effect which their application may be expected to produce.

Ideal treatment demands as its precedent a comprehensive diagnosis—in other words, the recognition of the facts of the case both physical and psychical, their interpretation and their arrangement in true perspective. No diagnosis can indeed be regarded as complete which does not aim at eliciting and explaining *all* the facts presented in the clinical picture. There is undoubtedly at the pre-

sent time a risk that the psychotherapeutic expert may, in his enthusiasm for procedures which, although apt to be regarded as innovations, consist for the most part in the application of principles with which the neurologist has for long been conversant in actual practice, overlook or disregard the significance of associated physical disorders, a correct appreciation of which may be of primary importance.

The mode of application of all physical remedial agents in the treatment of the neuroses is of essential moment. Suggestibility constitutes a striking characteristic of many neuropathic states. Consequently the physician, before he employs any physical treatment, must carefully weigh the probable impression the procedure is likely to produce upon the patient, and, even granting that he does not anticipate any benefit from the mental effect consequent upon its application, he must at least choose his words and apply the treatment in such a way as to avoid inculcating suggestions which may be prejudicial or serve to perpetuate fixed ideas. The truism that the physician treats his patient, and not the disease from which the latter suffers, is indeed singularly applicable to the treatment of the neuroses.

All those physical agencies which are utilized in the treatment of disease may be employed in the case of the neuroses. Among these, interpreting the term "physical treatment" in its widest sense, the following measures call for consideration, viz.:—Rest and exercise, massage, electricity, hydrotherapy, diet, drugs, and the use of local applications in the treatment of symptoms.

Rest and Exercise.—In every case the question arises, Should the patient be confined to bed or should he be allowed to be up and about? Confinement to bed may be of value because of the benefit to be derived from bodily rest, for purposes of moral discipline, or for reasons of convenience in the treatment of cases in which isolation is considered advisable. Patients suffering from

exhaustion neuroses or neurasthenic states associated with pronounced loss of weight and physical weakness should be put to bed and remain there for some weeks. On the contrary, in many cases of psychasthenia, phobia, and other neuroses there is nothing to be gained by confinement to bed, while in some actual harm may result from any attempt to insist on such a course. Again, a type of indolent neuropath is met with to whom a rest in bed is a real pleasure, which is not to be encouraged. In arriving at a decision as to the desirability or otherwise of this line of treatment, every case constitutes a problem calling for separate consideration with special reference to the patient's particular disorder and his mental attitude. This is not the place to consider the psychotherapeutic indications and contra-indications for isolation together with various subsidiary questions which arise if such a course is decided upon.

Massage is invaluable when confinement to bed is decided upon. The nutrition of the muscles is thereby maintained, the circulation is promoted, while the processes of digestion and the peristaltic action of the bowel are aided; massage, indeed, takes the place of exercise without entailing the volitional effort which constitutes one of the factors of physical fatigue.

The personality of the masseur is at least as important as the mechanical effect of the massage itself. The ideal masseur should be intelligent, cheerful, not too talkative, and possessed of tact. He should avoid expressing opinions upon facts that he may observe or upon medical matters generally, neither must he talk of other patients whom he is treating, nor discuss the patient's symptoms with him. While a tactful masseur may prove most helpful to the psychotherapist, an indiscreet one may do much to mar his efforts.

The massage should be "general"—that is to say, the whole body, limbs, and trunk, should be systematically treated. It may be ordered at any time throughout the

day, but not immediately before or after a meal. When insomnia is troublesome, this symptom is sometimes benefited by massage given in the evening about eight or nine o'clock. At first the massage should be light, and the séance, especially in cases of extreme exhaustion, should not last for more than twenty minutes. This period may be gradually lengthened to three-quarters of an hour. At a later date, exercises against resistance may be added. When the patient begins to get up and about the massage may be discontinued, since it no longer fulfils any useful purpose.

Electricity may at times be used with advantage in the treatment of the neuroses. This agent is sometimes employed for its general effect in producing contraction of the muscles, when it no doubt acts in the same way as massage, though it is probably in this respect much less effective. A simple faradic coil or battery is all that is required. The more important muscles are to be stimulated successively, a procedure which should occupy about three-quarters of an hour. Again, the faradic current may be utilized with great advantage as a means of persuasion or re-education in cases of functional palsy. The ability of the muscles to contract is in this way demonstrated to the patient. Intensive electrical treatment, a method utilized by the French in the treatment of certain war neuroses, consists in the sustained application of powerful currents, the results obtained being proportionate to the strength of the stimulus and the discomfort it produces. This procedure has, for obvious reasons, no place in civil practice.

A tendency to confuse hypothesis with fact, and the credulity of an impressionable public, account for the employment of various forms of elaborate electrical apparatus, which, so far as is known, possess no special therapeutic virtues apart from the sensation created by their presence. The utilization of such instruments is to be deprecated in the interests of medical progress.

Hydrotherapy.—Sinusoidal baths, whirlpool baths, hot and cold douches and the like, such as may be obtained at various health resorts and hydropathic institutions, have possibly a tonic effect, and carefully selected cases of neurasthenia of slight degree, more particularly stout individuals with a blood-pressure which is above the normal, may be benefited by a stay at places where such treatment is carried out. The beneficial effects are, however, probably to be attributed as much to the change of surroundings and the régime of the course prescribed as to any special virtue of the hydrotherapy.

Diet.—No special diet is, as a rule, called for in the treatment of the neuroses. Two classes of case are, however, exceptional in this respect. Firstly, cases in which there is marked loss of weight, and in which a rigid Weir-Mitchell course is considered desirable; and, secondly, cases in which gastro-intestinal symptoms are a conspicuous feature or in which it is affirmed that a variety of articles of diet produce dyspeptic symptoms.

When a strict rest cure is decided upon, it is well to give the patient nothing but milk in the first instance. He may begin by taking five ounces of milk every two hours, from seven in the morning till nine at night. Each day the quantity taken at a time may be increased by an ounce until he is drinking half a pint every two hours. The patient is not to be permitted to sip the milk from time to time as he feels inclined, but enjoined to take it when it is given to him. After the first three days he may be allowed to have a piece of dry toast occasionally, and a cup of weak tea at breakfast-time. In four or five days a milk pudding may be given at midday, and thereafter solid food is to be gradually added to his diet, the full quantity of milk being maintained. Many patients who, when in health, take little interest in their food, come to look forward to every meal after having taken nothing but milk for some days. Some patients affirm that they cannot take milk, but experience shows that

milk very rarely produces any gastro-intestinal disturbance. If this is actually the case, the addition of a small quantity of soda is often an effective preventive. When large quantities of milk are being taken, the tongue is apt to become furred, while flatulence, with associated abdominal discomfort and constipation, may be set up. These symptoms, may, however, be usually obviated if a simple powder, containing bismuth, rhubarb, and soda, is administered three or four times in the course of the day.

Many neurasthenics suffer from dyspeptic symptoms. Although a dyspepsia of nervous origin is, apart from the mental factor, uninfluenced by differences in diet, the analytical neuropath whose attention is focussed upon his gastric organs may, acting upon what he reads, upon the advice of his friends, or upon what he believes to be reliable personal observation, eliminate one article after another from his diet until he reaches a stage when it is difficult for him to find almost any form of food which he is able in his own opinion to take with impunity. All neurologists of experience will recollect instances in which patients of this type have continued for long to live on milk, and, it may be, some of the various proprietary foods, this restricted dietary having been arrived at by a fallacious system of reasoning of this kind. Under such circumstances it is obvious that, although the patient may clearly recognize the true nature of his symptoms after this has been indicated to him by the physician, the condition of the gastric mucous membrane may be such that the stomach is incapable of satisfactorily digesting solid food. This being so, it follows that it is wise to gradually increase the diet until digestive toleration is established, a plan which appeals to the patient's reason and is consequently of value from the standpoint of persuasion.

Drug Treatment.—Drugs play a subsidiary rôle in the treatment of functional disorders of the nervous system; indeed, in many cases there are no special indications for

their use. There is, however, still a prevalent belief that disease is to be cured either by the bottle or the knife, and the practitioner is consequently often compelled to pander to his patient by prescribing some medicinal agent to the physical effect of which improvement is very often erroneously attributed. The writer recalls in this connection a remark made by the late Professor Déjérine, who, when discussing a case of chorea in his out-patient clinique at the Salpêtrière, used words to this effect: "I shall prescribe arsenic in this case, not because I am convinced that arsenic is of undoubted value in the treatment of chorea, but because if I do not prescribe arsenic for this disease, the public will say that Professor Déjérine does not know how to treat chorea." The reputation of asafœtida and valerian, which were at one time freely prescribed in the treatment of hysteria and are still used for this purpose, is no doubt to be attributed to the suggestion which their unpleasant taste must necessarily produce. It is possible, indeed, that these drugs were first introduced in the hope that the characteristic above referred to would prove to be of special value in dispelling those evil spirits which were believed by our forbears to lurk about the system and originate the disturbances in question. There is, indeed, always a tendency to attribute improvement to physical causes, and the exclusion of the mental factor in determining the mode of action of a remedy is constantly a problem beset with difficulty.

Although drugs cannot be said to have any specific curative effect in relation to the neuroses, they are often of undoubted value. Thus the bromides are used for their sedative effect in conditions of restlessness and general nervous irritability. The writer is inclined to think that the ammonium salt is particularly serviceable in this connection. Strychnine and nux vomica are of value when exhaustion and fatigue are prominent symptoms, although their use is contra-indicated when there is

pronounced irritability and restlessness. Since these drugs are apt to aggravate insomnia, they should not be given late in the day. Arsenic certainly appears to be most useful in states of nervous exhaustion. The glycerophosphates, lecithin and nuclein, are widely used in cases of this kind, while Sanatogen and Ovaltine are often administered under similar circumstances. Recent observations have served to emphasize the fact that disturbances of the glandular secretions are frequent in certain of the neuroses. The effect of the emotions and of exhaustion states upon the secretion of the ductless glands is an engrossing problem; hitherto, however, advances in knowledge have done little to help practical therapeutics, although the future would appear to be full of promise.

The multifarious symptoms met with in functional nervous disorders demand no special consideration in this article, since they are for the most part to be treated on psychotherapeutic lines. Indeed, physical treatment of individual symptoms is better avoided, since it is apt, unless very skilfully applied, to focus the patient's attention upon the symptom in question and thereby intensify it. Insomnia, however, is a symptom which is an exception to the rule. Sleeplessness is one of the most troublesome symptoms met with in the neuroses; often it results, in the first instance, from mental worry or anxiety, while in turn it may be the precursor and cause of a train of symptoms, such as mental and bodily fatigue, defective memory and mental concentration, loss of confidence, etc. Sleeplessness is apt to become a habit which is, if possible, to be broken at all costs. If sleep improves, a general improvement may be initiated. Such measures as general massage, a hot bath or hot milk at bedtime, may be effective; often, however, these fail. Drugs may then be called for. The principle adopted is to commence with a fairly large dose, which is given for several nights, the quantity being gradually reduced without the patient's

knowledge. Twenty-five grains of bromide, combined with the same dose of chloralamid, may be given. Veronal and medinal, together with a variety of other drugs, are also employed for this purpose.

Complications, needless to say, are to be tactfully treated by appropriate measures.

THE HYSTERICAL FACTOR

CHAPTER IV

MECHANISM OF HYSTERIA

BY E. PRIDEAUX, M.R.C.S., L.R.C.P.

Captain (Temporary) R.A.M.C. Clinical Psychologist, Ewell War Hospital.

A. TERM "HYSTERIA" DEFINED.

Pathological origin a mystery—Disadvantage of meaning in common life and its application to war cases—Author's conception—Outline and criticism of term in different schools—Freud's general principles, justified in war experience, form basis for mechanism described. They recognize : (1) Importance of circumstances under which emotion was produced; (2) There is always a motive for symptoms; (3) Patient may be unconscious of motive as he is of actual process by which it achieves its end.

B. MENTAL PROCESSES.

Primary importance of recognizing mental processes may occur without realization of their existence—Influence of forgotten experiences in intuitive knowledge, abreaction, and post-hypnotic suggestion.

1. *Sublimation. The Process of Harmonizing the Complex.*

Nucleus of unconscious consists of primary instinctive impulses repressed as result of education and environment: (a) Individual Self. Result of innate dispositions of childhood. Governed by instinctive tendencies; (b) Social Ideal Self. Result of education, herd instinct, etc. Organized by self-regarding sentiment—The duty of Social Ideal Self, sublimation : (a) To protect from individual self; (b) To transfer energy derived from instinctive impulses into service of social ideal. Neglect of sublimation causes self-reproach.

2. *Pathological Repression.*

The failure to sublimate—Repressed complex remains active, seeks indirect expression, which expression constitutes hysterical symptom—It may take shape in psychical trauma which becomes exciting cause for symptoms deemed by consciousness physical factors.

C. PREDISPOSING FACTORS.

1. *Inborn Heredity and Over-developed Instinctive Tendencies.*

Freud maintained: (a) hysteric inherited constitution with excessive development of sexual instinct; (b) underlying sexual meaning in every hysterical symptom—Sexual instinct powerful factor in mental conflict, not satisfactory explanation for all cases—In War—Instinct of self-preservation giving rise to emotion of fear which dominates conflict—Other instinctive tendencies may be excessively developed, but whether these differences in child innate or acquired unknown.

2. *Social Heredity.*

Acquired, due to influence of parents and environment during development.

3. *Temperament and Character.*

Nature of temperament depends on: (a) varying degree in which instinctive tendencies developed; (b) different sensibilities to corresponding emotions—Character formation depends on way in which instinctive tendencies are sublimated.

D. SYMPTOM FORMATION AND PSYCHOLOGICAL TYPE OF INDIVIDUAL.

Nature of symptoms determined by psychological type of individual.

1. *Conversion Hysteria.*

Feeble development of social ideal, excessive development of instinctive tendencies produce lowest type—Dissociation of emotion attached to complex and its expression through Central Nervous System, indirectly.

2. *Anxiety Hysteria.*

Average development of social ideal, excessive development of instinctive tendencies—Symptoms and emotions expressed through Autonomic Nervous System. In both groups hysterical disposition may never manifest itself, but remain latent.

E. PHYSIOLOGICAL REACTION OF EMOTIONS.

Gain expression partly through Autonomic Nervous System—Counter-effect of physiological disturbances on emotions—Nature of conditional and unconditional Reflexes.

THE word "hysteria" was originally applied to the nervous crises occurring exclusively in women, and was afterwards extended and modified to include any physical symptom in either sex for which no organic lesion could be found, but its pathogenesis remained a mystery.

Everyone is now agreed that it is a condition of the mind, and that the symptoms are of psychogenetic origin;

as it is convenient to include under one heading all manifestations which have a similar mechanism for their genesis, the same basis for their symptomatology, and a common therapy for their removal, I propose to define hysteria as "a mental state manifesting itself by physical symptoms which can be removed by psychotherapy."

Whether we should continue to call this condition hysteria is another question, and in view of the popular ideas connected with the word, and the reluctance to label as such those cases in which the symptoms have appeared as the result of the strains of warfare, it would seem desirable to use some other term.

This definition includes all symptoms which have their origin in the repression of emotion; the apparent differences in symptomatology will be shown to depend on the psychological type of the person affected. Freud's term, "conversion hysteria," has been adopted for those cases in which the symptoms are expressed through the channels of the central nervous system, and represents the classical condition to which the name "hysteria" has been given by neurologists. The remaining cases in which the symptoms are expressed through the channels of the autonomic nervous system, and which are associated with anxiety states, are included under the term "anxiety hysteria"; the majority of cases of both civil and war psychoneuroses are in this class, and have usually been grouped under "neurasthenia" and "psychasthenia."

The term "anxiety neurosis" as distinct from "anxiety hysteria" is here reserved for those cases in which the anxiety is of physical origin, and is secondary to organic conditions of the viscera and endocrinic glands; such cases are not influenced by psychotherapy, and are not included under the definition of hysteria.

So much confusion has been caused by the nomenclature in use that, in order to understand the terms employed, it is necessary to outline the views held by the different schools.

Charcot paved the way for the understanding of the condition by showing that hysterical paralyses were dependent on ideas dominating the mind as a result of trauma. His theory was that, in a person already predisposed by heredity to hysteria, a blow on the shoulder for example, insufficient in itself to cause an appreciable lesion, produced enough pain to excite the idea of weakness in the arm, and so the idea of paralysis, which became fixed after a "period of meditation." This theory was the foundation for our modern conceptions, but it does not explain why a trauma should produce a symptom in the same individual at one time and not at another, nor does it explain the non-traumatic variety, and we know that trauma is not necessary to produce an hysterical symptom.

Janet followed with his theory of dissociation of consciousness, and regarded hysteria as an abnormal mental state, characterized by a tendency to dissociation of the ideas and functions that constitute personality. This was a great advance, explaining much of the symptomatology of hysteria and throwing light on such hitherto mysterious conditions as double personality, automatic writing, and amnesias, but his statement that dissociation is due to the weakening of the psychological synthesis does not help us to understand its mechanism.

The most simple and often quoted definition of hysteria is that given by *Babinski*, who has recently introduced the word "pithiatism" (that which is curable by persuasion) as a substitute. His definition is as follows: "Hysteria is a pathological state manifested by disorders which it is possible to reproduce exactly by suggestion in certain subjects, and which can be made to disappear by the influence of persuasion (counter-suggestion) alone."

This definition is only of value when the meaning assigned to "suggestion" is made clear, and *Babinski* does not do this; his interpretation of it excludes a large number of physical symptoms of psychical origin, curable

by persuasion, which cannot always be reproduced by suggestion.

The term "suggestion" has been used as a cloak to hide our ignorance of psychological mechanism, and when we say that a given condition is due to suggestion we deceive ourselves into thinking that we know all about it. If we seek further into the mechanisms of suggestion and persuasion we are forced to recognize that they are affective processes, and that the so-called state of suggestibility is the consequence of an affective state induced by the evocation of sentiments and emotions. Trotter has pointed out how one form of suggestion, "herd suggestion," is due to the action of herd instinct, and that "anything which dissociates a suggestion from the herd will tend to ensure such a suggestion being rejected," and that "to believe must be an ineradicable bias of man." It is owing to the influence of the herd instinct that we accept propositions in regard to religion, politics, and education. All such beliefs and opinions are non-rational, and are accepted by us as the result of accumulated suggestions.

McDougall also shows that in hetero-suggestion the personality comes into play in virtue of the relative strengths of the two instincts of "self-assertion" and "subjection." "Personal contact with any of our fellows seems regularly to bring one or both of these instincts into play," so that suggestibility is only evoked in us by persons who make upon us an impression of superiority of any kind in the particular situation of the moment.

If we allow that suggestion is governed by emotional processes, then we can say with Babinski that hysterical symptoms are produced by suggestion, but we shall have to widen his use of the word "hysteria." It would be equally correct to say that hysterical symptoms are produced by emotion and can be removed by emotion, if by the word "emotion" is meant also feelings and moods, or affective states. The disappearance of hysterical

symptoms as if by magic in the presence of danger, and the sudden recoveries reported in the newspapers, are explained by the fact that one affective state is substituted for another under the influence of an emotional shock.

In opposition to Babinski's suggestion theory is the conception of *Déjérine*, who has pointed out the preponderating rôle played by emotion in the genesis of hysteria; his view is that the origin of the hysterical symptom lies in some emotional traumatism, and that the fixation of the symptom follows after a period of incubation when the emotional shock, reinforced by internal emotion, has sounded the depths of the personality. Unfortunately, *Déjérine* has added confusion to our already unsatisfactory nomenclature by the introduction of a new meaning for the term "neurasthenia," which had hitherto been regarded by neurologists as a neurosis of organic origin. He regards hysteria as being due to a sudden emotional shock, and neurasthenia to the effect of prolonged emotion. "Neurasthenia," he says, "is constituted by a general *ensemble* of phenomena which result in the non-adaptation of an individual to any continued emotional cause, and the struggle of this individual to bring about such an adaptation." It is a mistake that a word which has been definitely applied to an organic condition should come in this way to be applied to a disorder of psychical origin, and should be adopted as the official term by the Army Authorities for such disorders.

It is difficult to understand what real difference exists for *Déjérine* between the ætiology of hysteria and that of neurasthenia, except the length of time over which the emotion acts. In the case of hysteria, the individual is taken by surprise and is unable to adapt himself to sudden emotional shock, whereas in neurasthenia the emotional cause must be prolonged and the struggle for adaptation continued for a longer period.

As both conditions are due to the influence of emotion

and are curable by psychotherapy, it seems better to classify them in one group as hysteria, and to restrict the term "neurasthenia" to the actual neurosis of physical origin.

We cannot regard Déjérine's theory as a sufficient explanation of the genesis of hysteria, for we know that emotional shock alone does not produce the symptoms. This is substantiated by the accounts of the medical observers who have examined the survivors of earthquakes; for example, after the Messina earthquake Neri examined over two thousand patients, and Bianchi five hundred patients, and not a single case of hysteria was noted; similar reports were made after the Valparaiso catastrophe. The reports of medical officers in the firing line and of those on torpedoed ships, quoted by Babinski, confirm his statement that. "when the human soul is shaken by a profound and sincere emotion, there is no room left in it for hysteria."

It is due to the work of *Freud* that we have a clearer insight into the mechanism of hysteria, and our experience of hysteria as the result of shocks and strains of warfare has amply confirmed his general principles. These principles are being accepted by psychologists, and form the basis for the mechanism here described. We now recognize that it is not so much the intensity or duration of the emotional stimulus which determines the outbreak of a symptom as the particular circumstances under which the emotion is produced, that there is always a motive for the symptom, though this may remain unknown to the patient, and that the actual process of achieving its end takes place without the patient being aware of it.

It is this presence of a motive for the symptom which has led so many people to look upon the hysterical patient as a malingerer. It is only when the action, in achieving its end, becomes conscious that a patient may develop into a malingerer. Another reason why those who do not understand the mechanism assume that the hysteric

is a malingerer, is that hysterical patients can temporarily put aside their hysteria, by a change in their affective state, when the situation requires particular concentration on some interesting function or amusement.

Mechanism.—The first essential in the understanding of the mechanism of hysteria is to realize the fact that mental processes may occur without our necessarily being aware of their existence. We know that we have a large store of experiences somewhere in the back of our minds, which we cannot bring voluntarily into consciousness, and we recognize that these forgotten experiences often influence our thoughts and feelings and give us our so-called intuitive knowledge. This action takes place by reason of the emotional tone associated with the experience, and in this way such experiences come to have the same force in guiding human conduct as our instincts. It is these forgotten experiences which prevent us from taking hold of a red-hot poker, for example, or which make us take an instinctive dislike to a man at first sight, or which often enable us to give a correct diagnosis of a difficult case without our realizing the line of reasoning.

The forgotten experiences can be recalled under hypnosis. An individual can be made to live through them again, as it were, and to express all the emotions originally felt at the time with an extraordinarily realistic effect and discharge of "pent-up" emotion; the expression of emotion in this way is called "abreaction."

The influence of forgotten experiences is well shown in post-hypnotic suggestion in which an idea implanted in the mind as the result of affective processes during hypnosis becomes realized in the waking state without the person having any conscious knowledge of its existence. This is very much what happens in hysteria.

Freud has shown that "forgetting" is an active process which he calls "repression" (for the mechanism of which see Chapter VI), and the region of the mind into which these ideas are repressed he calls the "unconscious."

These repressed ideas with strong emotional tone, which we call "complexes," attach themselves to a deeper layer of the unconscious, which is the nucleus of the unconscious. This nucleus is formed in childhood, and consists of the sum of primary instinctive impulses which have been repressed as the result of education and social environment. The primary innate dispositions in childhood are directed towards self-interests only and constitute the "individual self"; the result of upbringing, education, and environment, and the influence of herd instinct, subordinate these interests to those of the community and give rise to the "social ideal self," organized by the self-regarding sentiment, with which are associated the feelings of self-respect, family pride, patriotism, and the desire to do what is right in the eyes of our fellow-men.

The individual self strives simply to satisfy egoistic instinctive tendencies, it is pre-eminently selfish, it has no morals, it does not stop at anything to satisfy its individual ends, and it is quite ready to sacrifice the rest of the community for its benefit.

The social ideal builds up principles and ideals for daily conduct, it strives to aim at what a man would like himself to be, as tested by cultural requirements, it has its ideals of courage, love, honesty, truth, and self-control, all of which have been inculcated in him as the result of training and education, and especially by the influence and example of his mother.

The duties of the "social ideal" are to protect him from the "individual self," and to transform the energy derived from the egoistic instinctive impulses into channels which will be of service to the "social ideal" and the community, a process which is called "sublimation." Any neglect of these duties occasions in him feelings of remorse, self-reproach, and shame. The wish of the "individual self" to satisfy its egoistic instinctive tendencies is not compatible with the ideals of the social self, and the contest between the two gives rise to the pin-pricks

of conscience and to mental conflict. The discomfort produced by this conflict is removed by its repression into the "unconscious."

The process thus far described is a normal psychological one, and the way in which the repressed material is dealt with in the "unconscious" constitutes the difference between healthy and pathological repression.

If the "social ideal" is strong enough it overcomes the offending complex, assimilates it, and drains off the pent-up emotion attached to it by a process of sublimation, and thus, as it were, removes its sting and leaves it harmless for any further activity; this is the process of "suppression."

For example, sublimation and suppression take place in childhood in the form of games, later of hobbies, such as collecting stamps, butterflies, and birds' eggs, and then of sports; the man disappointed in love sublimates by going big-game shooting or by an increase in intellectual work; the old maid sublimates by a great activity in politics, such as becoming a "Suffragette" or a "Primrose dame"; and the childless mother sublimates by social functions and the keeping of pet dogs. In childhood the "social ideal" is not sufficiently developed to perform its function satisfactorily, and so the repression is incomplete and total suppression does not take place; this is the type of repression which is pathological in the adult when the "social ideal" has never been properly organized, or has been weakened by fatigue, alcohol, illness, or prolonged emotional states. We see this weakening of the social ideal in war-strained soldiers, who confess that their self-control weakens each time they go into the line, and also when they are feeling "done" as the result of fatigue or illness.

In pathological repression the "social ideal" is not strong enough to fight the complex successfully, and suppression does not take place, so that the complex is kept in a state of repression and remains active; it loses

all its associations, and thus becomes "split off" or dissociated from the personality; it is a source of constant irritation to mental life, and only waits for an opportunity to express itself.

It cannot do this directly without causing further discomfort, so that its expression, in order to be palatable to the personal consciousness, must be indirect, and is often disguised by means of symbols. This indirect expression of the repressed complex constitutes the hysterical symptom, which is therefore a compromise formation between the social ideal and the repressed complex, and is at the same time a solution of the conflict. An opportunity for the expression of the repressed complex presents itself in the shape of some psychical trauma, such as being blown up by a shell, being gassed, seeing a mate killed, bad news from home, disappointment in a love affair, or by some illness; these become the exciting causes for the symptoms which are deemed by the personal consciousness to be due to physical factors. The personal consciousness, being thus deceived, does not recognize the motive for the symptom which is to allow the repressed complex to express itself; and, as the mood or affective state associated with the pent-up emotion evoked by the complex is one of desire to satisfy its instinctive tendencies, the hysterical symptom resolves itself into a wish fulfilment.

Thus when the affective state is dominated by the desire to escape from some irksome duty or future danger, to astonish, gain affection, attract attention or sympathy, any idea harmonizing with this affective state becomes reinforced and realizes itself as an hysterical symptom without the personal consciousness being aware of the process.

The motive for the symptom has been very well shown in the war neuroses. It is everyone's experience in the hospitals at home that hysteria is very rare in a man who

has been severely wounded, even though at the same time he has suffered from considerable emotional shock. The wish to escape from the firing-line, which is in conflict with the social ideal, is gratified by the knowledge that he will probably never go back. It is also a common experience to see the hysterical symptoms develop in hospital at home, when the wound, if not incapacitating, has healed, or when the patient has recovered from some illness, and he sees the possibility of having to return to the front. The conflict becomes too great, and he takes refuge in an hysterical symptom. The same mechanism applies to those who have been put up into a higher physical category, or have orders to appear before a court-martial, and in these cases the diagnosis between hysteria and malingering is at times a very difficult one.

Predisposing Factors to Hysteria.—We have seen that the hysterical symptom is due to a state of repression, and that this in its turn is due to mental conflict.

But why does this repression occur in one man and not in another? Freud's view is that the hysteric has inherited a psychosexual constitution with an excessive development of the sexual instinct, and that there is an underlying sexual meaning in every hysterical symptom, using the word sexual in its widest sense to include affection, love, shame, and anything which is in any remote way connected with sexual activities. This theory has given rise to considerable opposition, and has prevented the more general principles from gaining recognition. The sexual instinct is a powerful factor in mental conflict, and as such plays its part in hysteria; but it does not seem to be a satisfactory explanation for war cases, for in the war neuroses it is the instinct of self-preservation giving rise to the emotion of fear which dominates the mental conflict. The other instinctive tendencies may also be excessively developed in childhood, and we know that in the same family the instinctive tendencies and sensibilities to emotion are developed in each of the children in varying

degree, but we cannot say whether these differences are innate, or acquired as the result of early infantile experiences. There can be no doubt, however, that the sexual instinct is the one most liable to repression in civil life, and it is in the domain of sex that we find the key to the origin of hysteria in peace-time.

More important than inborn heredity as a cause of predisposition is the influence of the parents and environment on the mind of the child during its development. A good deal of what has been put down to heredity in the past is in effect the result of this influence; the predisposition is not so much inherited as acquired. Association with timorous or cruel parents, and harmful experiences in early life, lay the foundations for the hysterical disposition. It has been previously pointed out that a state of repression depends on a lack of organization of the social ideal, and that this organization is the result of education and training in childhood. The struggle of the social ideal to overcome the egoistic instinctive tendencies of the individual self, and so to adapt the whole personality to its environment, constitutes the mental conflict, and when the social ideal is not sufficiently organized to perform its function, the conflict is avoided and repressed into the unconscious. In this way it comes about that temperament and character play important parts as predisposing factors in hysteria.

The nature of a temperament depends on the constitution of the individual self, the varying degree in which the instinctive tendencies are developed, and on the different sensibilities to the corresponding emotions, since each emotion has its own particular sensibility.

The formation of character depends on the way in which the social ideal is organized and strengthened to recognize, assimilate, and sublimate these egoistic instinctive tendencies. This is brought about by example and training in childhood, and the more highly developed the social ideal becomes, the greater the reasoning and

critical powers of the adult. If there has been little or no development of the social ideal, and the egoistic instinctive tendencies are excessively developed, then we get the lowest psychological type of individual. This type represents the classical hysteric, who gives an exaggerated response to inadequate emotional stimuli, but whose emotions are outwardly expressed. He makes no attempt at self-control, and acts on impulse; he is selfish and is always seeking pleasure; he gets rid of anything unpleasant by immediate repression; he is not a deep thinker, and is generally of low intelligence; he has been allowed to have his own way as a child, and when thwarted is unable to adapt himself, and takes refuge in illness by repression when an opportunity presents itself. As he expresses his emotions outwardly, so his symptoms are expressed outwardly through the paths of the central nervous system: these are the symptoms of the textbooks which Freud calls "conversion hysteria."

If there has been an average development of the social ideal, and the egoistic instinctive tendencies are excessively developed or have been over-stimulated in childhood before development of the social ideal, we get the anxiety type. He also gives an exaggerated response to inadequate emotional stimuli, but his emotions are expressed inwardly. He does not act on impulse, but tries to control himself and use his reason; he cannot make up his mind as to his actions, he is introspective and critical and often of high intelligence, he tries to face his conflict, and only when the social ideal can no longer hold its own does he repress, and even then the repression is probably not complete, for any stimulus associated with his conflict sets off an emotional reaction; his symptoms constitute Freud's "anxiety hysteria," and are expressed for the most part through the paths of the autonomic nervous system.

In both these groups of cases the hysterical disposition may never manifest itself, but remain latent, and our experience of the war neuroses has shown us that a man can

go through over four years of active service without showing any symptoms, and then finally succumb to an anxiety hysteria as the sequence of a severe psychical trauma; when the social ideal is poorly developed, he takes refuge in an hysterical symptom at the first opportunity, and as soon as he begins to rationalize that he has already "done his bit" his social ideal begins to weaken and he may become a potential hysteric; the prolongation of the conflict and the occurrence of a psychical trauma produce the symptom.

Symptom Formation.—We have seen that the hysterical symptom is an indirect expression of a repressed complex or complexes, and is a wish-fulfilment in the nature of a compromise formation. It may be the realization of an unconscious phantasy serving the wish fulfilment, when the complex is expressed by means of phantasy, in which the patient allows himself to be satisfied by the fulfilment of the wish in day-dreams and then represses it; under these circumstances he makes use of symbolism and hysterical crises. There may be several complexes linked up with each other, one of them at least going back to childhood, when his symptoms will be more complicated, some being due to one complex and some to another. The nature of the symptoms—that is, whether they are expressed through the central nervous system or the autonomic—is determined by the psychological type of the individual as already described. In one case we get "conversion hysteria," and in the other "anxiety hysteria," with or without some conversion symptoms. In both types of cases the symptoms are due to the expression of the repressed emotion attached to the complex, for the emotion must be always trying to expend itself and to find some equivalent means of manifesting its energy.

The normal expression of emotion in man is along the paths of the autonomic nervous system, and is shown by the reactions of the involuntary muscles and glands; only when it is excessive is it expressed through the central

nervous system, and shown by the reactions of the voluntary muscles under the control of volition.

In early childhood the emotions are expressed outwardly through the central nervous system by facial expression, sobbing when hurt, clenched fists and kicking when angry, and by running to the mother's apron-strings when frightened. As the child grows up and his social ideal becomes developed he is forced to hide the natural expression of emotion, to suppress the functions of the central nervous system, and to use the internal channel only; this he does through the autonomic nervous system. When we use the word "emotional" as applied to children and to persons possessing the so-called hysterical temperament, we should only mean that they express their emotions outwardly and do not keep them under control.

Conversion Hysteria.—In conversion hysteria either no attempt is made to face the conflict, or there may be a short struggle corresponding with the period of meditation, and then the emotion attached to the complex becomes completely repressed and dissociated and gains expression, as in the child, through the channels of the central nervous system, but in an indirect way, so that its motive is not apparent to the personal consciousness. The determination of the particular symptom depends on various factors. The emotion may simply fix symptoms which have already been produced as the result of emotional shock; for example, mutism, deafness, blindness, and these symptoms become useful in that they prevent the patient from talking about, hearing about, or seeing, anything connected with his emotional experiences.

It may fix symptoms due to actual physical trauma—for example, aphonia after gassing—or it may produce symptoms in some part to which attention has been drawn either at the time by a minor injury or at some earlier period by a previous accident; for instance, a slight bruise of the arm may be sufficient to cause an hysterical paralysis, or a superficial wound of the face may cause a facial paralysis

in a patient who had at one time suffered from Bell's palsy. The determination of the symptom may also be due to the fact that the patient has seen or known of someone who has been through similar experiences and has suffered from some particular symptom as a consequence, so that he himself expresses his emotions in the same way by a method of sympathetic expression : many cases of hysterical stammering occur in this way.

Another method of determination is that of "identification," in which the patient unconsciously identifies himself with someone whom he knew perhaps in childhood—his father or grandfather, for example—and whom he at one time wished to be like. If the person with whom he has identified himself had suffered from hemiplegia, then he would develop an hysterical hemiplegia. The hysterical attack is the unconscious realization of a phantasy serving the wish fulfilment.

Anxiety Hysteria.—In anxiety hysteria the social ideal at first tries to face the conflict, and only when it can no longer hold its own against the individual self is the complex repressed, and even then the repression appears to be incomplete. In these cases the patients generally tell us that they felt the symptoms coming on some time before they had their psychic trauma, and they generally recognize their previous conflict when it is presented to them, whereas the conversion case does not realize that he has ever had a conflict. The repressed emotion is directed along the paths of the autonomic nervous system, and the derangement of function of the viscera and endocrinic glands thus produced excites, by repercussion, a further emotional reaction with the production of anxiety.

This anxiety cannot be attached to the repressed complex, and is consequently transferred to some other idea which is assimilable in consciousness. In this way are formed the numerous phobias from which these patients often suffer, and at the same time a vicious circle is set up. The nature of the phobia is determined by the conditions which were

associated with the repressed complex; thus if a child has been shut up in a cupboard, and there has been associated with this some mental conflict which has been repressed, then that child will be likely to develop claustrophobia.

The work of Pawlow, Cannon, Elliott and others has demonstrated the physiological reactions of the emotions in animals, and has shown that they gain expression partly through the channels of the autonomic nervous system. Cannon has also shown the opposing effects of the sthenic and depressing emotions along the antagonistic paths of the autonomic system, the sacral and cranial on the one hand and the sympathetic on the other.

The sthenic emotions such as joy, hope, and confidence, steady the heart-beat, stimulate the secretion of the saliva and gastric juice, and keep up the muscular tone of the alimentary canal and external genitals. The depressing emotions, anxiety, fear, grief, rage, and pain, produce rapidity of the heart-beat and cessation of the secretion of the saliva and gastric juice; they stop the movements of the alimentary canal and interfere with the normal function of the genital organs; they excite the sweat glands to secrete and stimulate the secretion of the adrenal gland; the secretion of the adrenal gland increases the blood-pressure, and also gives rise to glycosuria. These are the ordinary physiological reactions of the emotions, and are of the nature of reflexes.

We have also evidence that disturbances in the viscera and endocrine glands affect the emotions; we know the beneficent influence of a good meal and healthy exercise on our moods, and we realize the disturbing effects of constipation; we recognize the change in the emotional states in the exhaustion and toxic psychoses, and in Addison's disease and visceral cancer; and the work of Sherrington on the "Integrative Action of the Nervous System," and that of Orr and Rows on the "Interdependence of the Sympathetic and Central Nervous System," go to support the view that an emotion must be looked upon as consisting of an

entity which may be stimulated by either physical or psychical factors, so that the reactions excited by emotion may in their turn excite emotion.

Pawlow has called the reaction to a normal emotional stimulus the "unconditional reflex," and has shown that any stimulus, artificially associated with it sufficiently often, produces the same reaction when substituted for it: this he calls the "conditional reflex." (Thus if a dog is shown fresh meat its stomach secretes gastric juice, and if the meat is afterwards associated with the blowing of a whistle or the flashing of a light for a sufficient number of times, then the whistle or the light will excite the secretion.) He has also shown that the conditional reflex is inhibited when yet another stimulus is associated with it.

We have long recognized that when two mental states are associated together for any length of time or with sufficient vividness for a short period only, then the calling up of one state will always call up the other, and we must surmise that the one state is conditioned by the other by a similar mechanism to that which produces Pawlow's conditional reflex; this mechanism is used in the training of animals; for example, the war dogs attached to the Signal Service in France were trained by exploding bombs close to them whilst they were being fed, so that they were able to associate terrifying noises with the pleasant idea of food.

It is evident that the physical symptoms produced in the anxiety cases will be those of the reflex reactions of the depressing emotions, which may be conditioned by the repressed complex. Some will be common to all cases, such as sweating and pallor, and others will be determined according to the principles already laid down for the conversion cases. Thus we may get disordered action of the heart, disturbances of the respiration such as asthma, dyspepsia, constipation, increased frequency of micturition, and sexual impotence. In the same way that conditional reflexes excite the secretion of gastric juice, so does any stimulus associated with the repressed complex excite the

same emotional reaction as the complex did originally. As the patient has repressed the complex, he cannot account for these exaggerated reactions to inadequate stimuli, and is unable to put up any inhibition against them until he knows why they occur. He cannot be cured until the complex is released from repression, unless the functions of his eyes, nose, ears, and viscera are removed, for he will continually be receiving stimuli associated with his complexes for the rest of his life.

CHAPTER V

TREATMENT BY SUGGESTION AND PERSUASION

BY J. A. HADFIELD, M.A. (OXON), M.B., CH.B. (EDIN.)

Formerly Surgeon R.N. Medical Officer, Ashurst War Hospital for Neurological Cases.

INTRODUCTION.

Value of war neuroses in study of functional disorders—Attitude of physician to patient.

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Depending on authority and expectancy—Illustrations.

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Reassociation.

Morbid associations dissociated then reassociated with healthy thoughts—Nature of proper suggestions—Tonic, specific, positive, amnesic, self-reliance.

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Collective Hypnosis.

Twenty to twenty-five hypnotized at once—Suggestions: tonic, specific—Hypno-analysis individually in private—Reassociation collectively—Advantages of this method.

TREATMENT BY PERSUASION.

Definition, clinical not scientific term—Value compared with suggestion—Illustrative case: "Psychopathological man."

Methods Employed.

Examination and reassurance of patient—Elucidation and explanation of patient's nervous disposition, pains; associate, sympathetic, and spasms, contracture, flaccidity, aphonia—Demonstration to patient's senses nature of symptoms—Re-education—Exercise of will—Physical exercise.

THE war, it is said, has not revealed any new forms of the psychoneuroses, but has merely recapitulated types of functional disease already known in civil practice. While this is probably true, the cases presented to us by the war are so simple in their ætiology, and the factors which contribute to their production so well-defined and uncomplicated in character, compared with those in civilian cases, that we have the opportunity of studying them almost under laboratory conditions. Moreover, so many of these are practically identical in origin and symptoms, that they constitute excellent material for testing and comparing the various methods of treatment. The methods suggested in this paper are derived from this process of experimental comparison. The spirit that divides the schools of psychotherapists into rival factions is valuable for discovering the possibilities in any special kind of treatment, but when it takes the form of exclusive dogmatism it has no place in scientific research. Almost all methods, whether persuasion, drugs, suggestion, or analysis, are found to be efficacious in special cases, and it is the business of the psychotherapist, holding them all at his disposal, to discover which is the most effective to apply to each type of case. The methods described in this chapter have withstood the test of practical

experience. They are not, however, the only ones advocated for the treatment of neuroses, but should be considered as complementary to the more prolonged and radical methods of analysis described later, which only the specialist can be expected to use effectively. There are chronics, of whom it may be said that the only cure possible would be to analyse them back to the blastoderm, and thereafter reconstruct them afresh.

The attitude of the physician to the patient should be one of complete frankness and confidence. Personally I always make a point of telling the patient the extent of any organic lesion he may have. A disease feared is often more distressing than the knowledge that one has it. When tempted to use cold douches, sudden shocks, and other "modern equivalents of the rack," let us remember that it may often be necessary to humble, but never to humiliate. It is wise also to remember that a pain or other symptom may arise in the imagination without being "imaginary" in any sense that the patient can be expected to understand.

TREATMENT BY SUGGESTION

There are two main forms of suggestion, hypnotic and waking. In the former the mind of the patient is dormant, whereas it is not so in the latter.

Suggestion is the process by which ideas are introduced into the mind of a subject without being submitted to his critical judgment. The effect of any suggestion depends upon its evading the critical judgment of the reason. The definition corresponds with the use of the word "suggestion" in ordinary language. When we "merely suggest" an idea, we mean that we are not prepared to defend it against antagonistic criticism. A "suggestive" story is one which defies criticism on account of its "double meaning"; it insinuates what it does not openly declare.

Suggestion is concerned with ideas alone, and is distin-

guished from sympathy which is the transmission of emotion, and from imitation, which deals with the reproducing of actions, such as is demonstrated in latak.

Waking Suggestion.—Waking suggestion depends for its force chiefly upon the authority of the physician and the expectancy of the patient, both of which factors tend to make the patient accept ideas without question or criticism. With a patient sufficiently suggestible, even in the *fully waking state* and though he has never been hypnotized, one can make the suggestion of anæsthesia, and then put a pin through his skin without producing the slightest pain; or can compel him by waking suggestion to perform various movements. However hard the patient tries to act contrary to the suggestions, he finds that they dominate his mind and actions. The announcement, forcibly delivered to a paralytic patient in the waking state, that he can and will walk, sometimes produces the desired result, in some cases instantaneously. Such a patient is not to be considered a malingerer because he is cured by “stern” measures. Electricity has been used very effectively during this war as a form of waking suggestion in cases of aphonia, and even paralysis. It is possible that in some of these cases the electricity actually breaks down a resistance in the nerve path; but in other cases the cure is undoubtedly brought about by the suggestion of the electricity; the bluer the light, the more crackling the spark, the higher the frequency, the more effective will be this method of cure! Some physicians would argue that any method which cures is legitimate. But this treatment makes its appeal to the ignorance and credulity of the patient, and its prolonged use often merely confirms him in his belief that he is incurable.

Hypnoidal Suggestion.—The hypnoidal condition is one in which the patient’s mind is put into a quiescent state, and rendered receptive and uncritical. In this state he hears and remembers all that the physician says, but does not concern himself to criticize the ideas, which therefore enter

the mind as suggestions, and tend to work themselves out in thought, feeling, and action. This method is often termed "waking suggestion," but the induced condition can scarcely be characterized as "waking," since the patient is on the very threshold of sleep. However, the use of the term "waking" instead of "hypnoidal" has the advantage of sparing the feelings of those to whom the word "hypnosis" suggests something weird and uncanny.

The essential difference between hypnoidal and hypnotic suggestion lies in the extent to which mental associations are still possible. The "depth" of the hypnosis depends on the relative inability to form associations with the other ideas and dispositions of the mind. There are times when hypnoidal suggestion, in which the paths of association with other dispositions of the mind are still to some extent left open, is more effective than hypnotic suggestion, in which almost complete dissociation is produced. In hypnoidal suggestion we may keep an idea, say that of "confidence," dominant in the mind, and its influence will flow down, as it were, along the paths of association and overwhelm the other dispositions of the mind while these lie dormant and passive. In such a case, a condition of more complete dissociation, such as one gets in deep hypnosis, would be *less* effective, since the suggestion, before it could act on surrounding dispositions, would have to break down the barriers and resistances set up by the formation of the dissociation. This accounts for the fact that, in actual practice, treatment in the hypnoidal condition is often more successful than in the deep hypnotic. On the other hand, there are circumstances, to be described later, in which deep hypnosis is preferable.

Hypnotic Suggestion.—In deep hypnosis the patient's power of criticism is almost completely in abeyance*; that is to say, the ideas suggested are so completely dis-

* We say "almost completely," for even in the deepest hypnosis the mind appears to possess some power of criticism, which prevents even a deeply hypnotized person from doing what is morally repugnant to him.

sociated that surrounding dispositions have no influence upon them. Consequently amnesia results, for when the patient wakes he has virtually no links of association to recall what has happened. Amnesia is perhaps the best single test of hypnosis as distinct from the hypnoidal condition: but it should be remembered, by those who use waking or hypnoidal suggestion and decline to use hypnosis, that the difference between these conditions is only a matter of degree, depending on the extent of dissociation. The greater degree of dissociation, such as we attain in deep hypnosis, is preferable, and sometimes necessary, in the following circumstances:

1. The recovery of amnesia is one of the most important features of our method. Hypnotism is frequently the only method for the recall of amnesias. Some physicians, who otherwise discourage the use of hypnosis, advocate it for this purpose. But such physicians often fail to realize the extraordinarily large number of cases in which important amnesias occur. Our patients often tell us that they "remember everything," whereas, under hypnosis, they are found to recall repressed complexes that they had entirely forgotten. On looking through my notebooks I find that by far the majority of the cases treated by hypnoanalysis revealed hidden repressions of this kind, the bringing up of which was necessary to complete cure. All real repressions we should include as "amnesias." Deep hypnosis is also frequently the only method for the recalling of dreams which are forgotten but yet trouble the patient. The recovery of these dreams is often necessary to lay bare an important repression and may constitute the turning-point in the cure.*

2. Deep hypnosis is also very useful when the morbid

* Even in cases of apparent organic concussion, e.g., when a patient was unconscious for weeks owing to a shell wound in the frontal bone, which entailed the removal of a piece of bone two inches in diameter, or where a bullet has passed through the brain, the complete amnesia has been recalled.

condition of the patient's mind forces him, however unwillingly, to resist the healthful suggestions offered. Under hypnotism these morbid ideas are rendered dormant, and strong complexes which are otherwise obstinate may be overcome. A patient of mine heard voices telling him he was going to die; in place of this voice, laid to rest in hypnosis, I suggested that he would hear my own continually telling him he was going to be well, with the result that he is now perfectly cured of an obsession which would almost inevitably have led to the asylum. Argument and persuasion had been elsewhere tried for months in vain.

Deep hypnosis is, of course, desirable in cases of insomnia, or when prolonged rest is necessary. I put to sleep two "shell-shock" patients for two days and two nights, waking them for their food only. As a result of this "potted" Weir Mitchell treatment they wakened fresh and composed, and free from their former symptoms.

The Use of Hypnosis.—A few remarks on the use of hypnosis may clear the way for a discussion of its uses in treatment.

1. It is assumed that in using hypnotism we are employing a method the essential nature of which is shrouded in mystery, and which is therefore dangerous.

2. It is suggested that hypnosis is a condition of dissociation, and that we are therefore simply trying to cure one form of dissociation, namely hysteria, by another.

3. It is suggested that only a few patients can be hypnotized successfully, and that therefore the scope of this method is limited.

4. Some physicians have abandoned the use of hypnosis, not because of any objection to it in principle, but because they have not found it successful in practice. This chapter may help to point out some of the commonest errors in the use of hypnotic suggestion, and illustrate its correct use in conjunction with hypno-analysis and reassociation.

(1) The essential feature of hypnosis* is, theoretically,

* See art. Hypnotism in *Encyclopædia Britannica*, by McDougall.

one of dissociation, or the splitting off of ideas or groups of ideas from the rest of the mind; practically, the essential features of hypnosis are (a) a condition of *correspondence* (commonly called "rapport") between the physician and the patient; (b) a condition of *suggestibility* in the patient's mind such that all suggestions of the physician tend not only to persist as ideas, but to express themselves in conduct.

(a) *Correspondence*.—The term "hypnosis" indicates that the condition is one of sleep; but hypnosis differs from ordinary sleep in that, in the latter, the patient is in correspondence with his own thoughts alone (as in dreams), whereas, in hypnosis, he is in correspondence with the physician and usually with him alone.

A simple analogy of the correspondence experienced in hypnosis is found in the case of a mother, who may be fast asleep to all the world, but instantly hears the faintest cry of her child, with whom alone she is in correspondence, as the subject is with the hypnotizer. Again, a child may be asleep to all the world, but if his mother speaks to him in his sleep, he may, being suggestible, not only hear, but even reply without waking. So the hypnotized patient is in correspondence with the physician, but dissociated from all the rest; he is, as it were, "sleeping with one eye open." There is no more mystery about such "correspondence" in hypnosis than there is in these natural phenomena of normal sleep.

(b) *Suggestibility*.—A condition of suggestibility is induced by the physician closing all the avenues and channels to the mind except the one in correspondence with himself, down which the suggestions are therefore directed with concentrated effect, as the voice directed through a megaphone. The suggestions thus enter the mind with increased potency. Having once entered the mind, these suggestions, being cut off and dissociated from the inhibiting influence of other ideas, tend to dominate the mind with unchallenged sway.

(2) Hypnosis, like hysteria, is a form of dissociation. Hysteria is *pathological* dissociation: hypnosis makes use of dissociation for *therapeutic* purposes. While hysteria is a morbid dissociation brought about by conflict in the mind, we have in hypnosis the power of dissociating or breaking apart ideas that have become morbidly associated; after we have dissociated them, we may reassociate their elements with healthy ideas. This power of dissociating and reassociating is most valuable in treatment. One patient of mine could not bear the sight of any officer, because an officer's uniform was associated in his mind with a "British" captain who was in reality a German spy, and whom my patient had exposed as a traitor at very considerable risk to his own life. Another patient, who was blown up, complains that every noise "strikes him in the back," simply because the explosion was originally associated with pain in the back. Such morbid associations, of the officer's uniform with fear, of sound with pain, need to be broken; their elements must first be dissociated from one another, and then each reassociated with healthy thoughts and emotions; both the dissociation and reassociation can easily be brought about under hypnosis.

(3) It is said that the number of people who can be hypnotized is strictly limited. It is true that a large number can never be made to "lose consciousness" or become amnesic, even by the most skilled hypnotist. To test the proportion of people who can be hypnotized, I hypnotized at once seventeen patients taken at random, and stuck a pin through a fold of skin in the hand of each one. As many as ten were found to be amnesic, or "fast asleep," to such a degree that, when they woke, they were unconscious of what I had done—i.e., they were in a condition of deep hypnosis. Of the remaining seven, six felt the putting in of the pin, but said they experienced no pain whatever—i.e., they were in a hypnoidal condition. Only one out of the seventeen said he felt any pain, and he, curiously enough, ordinarily suffered from hysterical

anæsthesia ! Thus sixteen out of seventeen were analgesic and highly suggestible. A large majority of patients are sufficiently suggestible for treatment even though amnesia is not produced. The fact that the patient is "conscious" of what is said matters little, so long as he is not critical.

(4) The question as to the effectiveness of hypnotic suggestion is to some extent answered in the general course of the chapter.

Symptomatic Treatment.—It is obviously unscientific to treat symptoms rather than causes, and failure of hypnotic and other forms of suggestive treatment is frequently due to this practice. Many patients have been treated for weeks and months by hypnotic suggestion, massage, or electricity, without any appreciable effect ; simply because the suggestions were directed towards the symptoms, and not to the underlying causes.

In hysteroid conditions, however, in which the symptom is the main factor, treatment directed primarily towards the symptom may not only get rid of the symptom, but also cure the disease as a whole—in other words, the cure of the symptom breaks the vicious circle and so completely cures the disease. It is obvious that all those disorders generally grouped as "habit" pains or "habit" spasms, and due as a rule to morbid associations, can be rapidly cured by this method. The removal by suggestion of a "habit" contracture, for instance, not only cures the contracture, but also the patient's false conviction that he cannot move his arm. Again, the vigorous toning-up of a patient's determination and will may give him the necessary strength to overcome his emotional instability, although no diagnosis of the specific cause has been found.

I mention such cases as these, not so much to advocate symptomatic treatment, as to show why such treatment is not infrequently successful.

Hypno-Analysis.—It is generally agreed that many of the functional nervous disorders originate in painful experiences that have been suppressed, and often completely forgotten,

because they are in conflict with the dominant ideas and emotions of the mind. So long as these repressions lie buried they are apt, like a septic foreign body, "to light up the infection." The most radical cure for such disorders is to discover the repressions, bring them into consciousness and there sublimate them. The methods of psycho-analysis, psychological analysis, word associations, and the interpretation of dreams, are at present widely employed for the purpose of discovering the latent complex; but these methods are often long and intricate and require considerable skill. The method which I venture to name "Hypno-analysis" consists simply in hypnotizing the patient and inducing him to speak of his troubles, which he usually does freely and without reserve. I find this to be the most direct and certain method of discovering repressions which lie below the level of consciousness, but which, in the state of hypnosis, may easily be brought to the threshold.

The method of hypno-analysis is as follows: The patient is hypnotized, and is told that, when the physician puts his hand on his forehead, he will visualize all the circumstances and again live through all the emotional experiences which produced his breakdown; and he is encouraged to describe them as he sees them. In "shell-shock" cases the patient usually becomes disorientated, shows signs of great emotion, trembling, perspiring, engages in violent movements, and may be speechless with horror or cry out with fear. In civilian cases, which are usually of long standing, the process is a little more prolonged and complicated. Starting with one of the symptoms from which the patient suffers—say, an hysterical "neuralgic" pain—he is made to recall, under hypnosis, the first occasion on which he was troubled with the symptom; after discovering its cause, the physician proceeds to deal with other symptoms, until all the events that combined to produce the condition have been laid bare.

Several points of practical importance may be mentioned:

1. We may suspect that we are on the track of a repression either when the patient makes a jump in his narrative and skips over a considerable period in his attempt to avoid the painful incident ; or, on the contrary, when he begins to describe events in the minutest detail, as though skirmishing round the outskirts of the repression and reluctant to come to the point.

2. When encouraged to speak of his repressions under hypnosis it is found that the patient sometimes " wakes up." In such cases, however, we may prevent the waking by " suggesting " against it, and telling him that he is dreaming and speaking in his sleep. On the other hand, there are many cases in which, far from waking the patient, the attempt to recall the repression drives him into a deeper sleep. Even when he is only capable of a light hypnoidal condition, he may, if the physician keeps the repression " dangling " before his mind, suddenly seize it and become so absorbed with it that he is driven further into hypnosis and speaks of it freely. The fact that a patient is only capable of light hypnosis should not, therefore, discourage us from attempting to discover his repression by hypno-analysis.

3. If difficulty is encountered in discovering the repression by ordinary hypno-analysis, the following methods will almost invariably succeed :

(a) Suggest to the patient that, though he cannot tell you the repression under hypnosis, he will be able to do so on waking.

(b) Induce the patient to remember a dream which troubled him and which he may have forgotten, and suggest that he will dream it again and describe it.

(c) Persist in your determination, and tell him that he will not leave the room till he has divulged the repression. Such persistency nearly always succeeds.

(d) Suggest to him that he will dream about the repression that night, will remember his dream, and tell you in the morning. By this method we cured, amongst others, a man who, owing to a shell explosion, had lost his memory from

childhood, and did not recollect even his own name. Though he had been hypnotized elsewhere for months, previous efforts to bring back his memory had failed.

4. If the repression, though remembered under hypnosis, is not remembered in the waking state, the patient remains uncured, the repressed complex being still dissociated. This can be righted by telling him, when he has recalled the repression under hypnosis, that he will recollect the forgotten incidents after he wakes. The true memory of the event is thus linked up with consciousness. A patient with a negative headshake of about 30 degrees told me, under hypnosis, that the complaint originated when he was in hospital at Dunkirk which was being bombed by German aeroplanes. In order to reassure himself, he kept repeating to himself, "They will not bomb the hospital. No! no! no!" He shook his head, and continued to shake it for several months afterwards, in a manner most distressing not only to himself, but to those around him. But though the cause of his headshake was easily and rapidly diagnosed by hypno-analysis, the headshake continued with only slight improvement until two days afterwards, when I brought back to waking consciousness the cause of his complaint, after which the headshaking subsided so rapidly that in a few hours it had quite ceased.

Let us now consider the kind of cases that may be successfully diagnosed and treated by hypno-analysis.

(1) *Motor Symptoms*.—Many of our patients suffer from hysterical tics, spasmodic movements, and functional paralyses. The discovery of the origin of these disorders leads not only to cure of the symptoms, but also to the discovery of the underlying emotion which frequently, perhaps always, accompanies and even produces them. One patient, whom I had cured of so-called "contusion of the spine," which had prevented his walking, was still observed to have a curious choreic movement of the hand. On being questioned, under hypnosis, as to when he first had this movement, he replied: "Officer; hand blown off;

I had to bandage it up." He was told to remember this on waking, and the tic never reappeared. Another patient suffered from "fits," which were initiated with a forward thrust of the shoulders and shake of the head. Under hypnosis, he explained that the first time he had a fit was during a route march prior to being drafted to France, where his brother had recently been killed; that the thrust of his shoulders was due to his pack being very heavy and paining him so that he wanted to throw it off. The movement was, evidently, in imitation of the throwing off of the pack, and the patient has never had a fit since this fact was discovered.*

(2) *Sensory Conditions*.—I find a very large number of my patients suffer from a "habit" pain of some kind. I would suggest, as a better name for such pains, "associate pains," as their persistence appears to be due to their association, whether accidental or causal, with some emotional condition. When the emotion is awakened the symptoms associated with it are also aroused. One of the commonest complaints met with in this war is the persistence as "after effects" of the pains and tremors characteristic of trench fever, influenza, or malaria, which linger on long after the fever itself has subsided. It is found on examination that in these cases the patient originally suffered from the fever when under great emotional strain, such as a severe bombardment. This might be considered merely accidental, but the "associate" nature of the pains is proved by the fact that in the large majority of cases they rapidly disappear when the emotional condition is cured in hypnosis, even though they have resisted months and even years of "organic" treatment. I have therefore been led to the conclusion that a large number of chronic pains are of the "associate" type. An "associate" pain, then, is a pain

* I suspect that the movement of the shoulders was associated not only with the route march and his approaching draft to France, but that it was also partly symbolic of throwing off the irksome and painful burden of military service.

which was originally organic,* but, being at the time associated with a strong emotion, tends to persist with the repression of the emotions long after the organic basis has disappeared. Such pains are rapidly cured by the dissipation of the emotion.

My batman suffered every Christmas-time, and only at Christmas-time, from facial neuralgia. Under hypnosis, he informed me of an incident previously forgotten when, at the age of fourteen, he had gone to have a tooth extracted by a dentist who squirted the cocaine into his mouth instead of injecting it into the gum. The patient swallowed it, became unconscious for two hours, and feared he was going to die. This had occurred "three days after Christmas" ten years previously, the exact day on which the neuralgia actually reappeared. With the recollection and explanation, the neuralgia immediately disappeared without further treatment. Another patient had a habitual pain in his stomach, which, he said under hypnosis, he had had before he was born! Regarding this as a somewhat precocious memory, I asked for an explanation. Once, when he had a "stomach-ache," his mother had told him that she had had such a pain three months before he was born, and that it was "in the family." This pain also disappeared when the origin was explained to the patient. Hypno-analysis has thus been most valuable in showing the functional nature of pains previously considered organic.

The proof that the pains in their present form were not organic is suggested by these facts: first, that the patient himself directly and unhesitatingly, in hypnosis, divulged the cause of their persistence as of an emotional kind; and, secondly, that a permanent cure of the pain resulted from the treatment.

(3) *Mental and Emotional Conditions.*—Besides peripheral

* It will be observed that this definition of "associate pains" differentiates them from pains of a purely functional character, such as "sympathetic pains," and I would apply the term "associate" only to those which were organic in origin.

conditions—motor and sensory—central disorders of ideation, such as the cases of obsession mentioned elsewhere, emotion, such as phobias, and will, can be discovered and cured.

It is chiefly in suppressed and repressed emotional conditions that hypno-analysis is of value. When discovered, the suppressed emotions are often liberated with such violence that the patient is thrown into a state of great excitement and commotion. The liberation of the affect, whether of fear, anger, sexual feeling, or other emotion, itself seems to relieve the patient considerably, but this, in our opinion, is not the real cause of the relief, as we shall observe in the next section. Again, it is frequently found that more than one repression goes to the production of a psychoneurosis, and it is necessary, in order to bring about a complete cure, to discover repressions of a minor sort. A patient who had suffered from sleeplessness for thirteen years was almost cured of this by the discovery of a deeply buried repression, but was still unable to go to sleep if he went to bed after eleven o'clock. Under hypnosis, he told me that this was due to the fact that his father had never allowed him out after eleven, even when he was of age. One night he stayed out after this hour, had an altercation with his father, and subsequently suffered from the first sleepless night he had ever had. The discovery of this secondary repression completed the cure.

Reassociation.—A patient who has a repressed fear, due to having been buried by shell-fire, may be greatly relieved by the outburst of feeling produced under hypnosis. In our opinion, however, it is not the liberation of the affect or "abreaction" that cures, but the reassociation of the event with a healthy emotion. In such cases the reassociation is worked out automatically in the patient's mind: he says, in effect, "It is all past and done with: there is nothing more to worry about." Our view that it is not the liberation of this affect alone that produces the cure is supported by the fact that very frequently the recollection

of his experiences merely throws the patient into a state of deeper misery and anxiety, from which he can be delivered only by the formation of new associations. It is usually automatic in cases where the problem, once recognized, is faced and solved by the patient himself, as in the present circumstance of "shell-shock" patients, in which the urgency of the emotional conflict between self-preservation and the sense of duty has passed away with the cessation of hostilities. But where the patient has still to live in the same environment and face his old problems, it is not only necessary that he should be made to recognize these problems, but he must be taught to react healthily to his circumstances by reassociation.

The sight of an *aeroplane* is associated with the onset of *fear* in a patient who was once bombed: he needs to reassociate this sight with *gladness* and gratitude at his escape, instead of with morbid fear. The banging of a door produces pain in the eyes and a flood of tears in a patient who was the victim of a gas shell. This association must be broken and the patient taught to be indifferent to noise. The civilian who becomes *sick at heart* when he thinks of his *business* which is failing must be made to reassociate the thought of his *business* with *determination* to succeed. Reassociation should follow immediately upon the hypno-analysis, and the patient should not be permitted to wake from his hypnosis until the new reaction has been formed. It will be perceived how important is this process of reassociation.

It is also necessary that *our suggestions should be of the right kind*.

(a) First of all we need to give *tonic suggestions*, intended to raise the whole mental and moral tone of the patient; strong suggestions of cheerfulness, of confidence, of vigour of mind and body, of altruism and thought of others, thus throwing the moral weight of the physician on the side of healthy thoughts and inspirations.

(b) There are also *specific suggestions* destined to counter

definite morbid thoughts and to reassociate them with healthy emotions. Such suggestions should be positive: better to induce healthy thoughts than merely to dismiss morbid ones. The suggestion that a headache will go, that the neuralgia will cease, that the arm will no longer be limp, may only serve to leave the impression of "headache," "neuralgia," "limpness," on the mind of the patient, and he will receive no benefit from them. Suggest that the head will be "easy," or "light," or "cool"; that the face will feel soothed; that the arm will be invigorated with warmth and strength, and these suggestions will dominate the mind and cure the body.

(c) Should we suggest to a patient that he forget all about his troubles? Forgetting by repression is one of nature's methods of getting rid of a painful memory. On the other hand, it has been shown that to repress a painful memory is one of the most fertile sources of the neuroses. There are, however, two processes included under the term "forgetting": there is the active forgetting of a painful event which we term "repression"; there is also the ordinary forgetting of indifference. It is never advisable to encourage forgetting an event, so long as there is an associated emotion. In one case only did I attempt to repress still more deeply an emotional complex in a man who had been blown up and had forgotten the event, and his subsequent relapse prevented me from ever repeating the experiment. Indeed, even in those cases where the patient, by the lapse of time and the process of nature, has buried his repression successfully, it is best to insist on recovering the memory, for, however much such a patient may protest beforehand that he is "quite well," he feels an extraordinary and unexpected sense of relief when the memory is restored and the repression let loose. Herein medical art by its method of analysis and reassociation has improved on nature with her method of repression. But when the patient has been made to bring up the repression, and by reassociation to face his conflict without

emotion, then it is advisable to suggest that the whole thing be dismissed from the mind as a matter of indifference.

(d) *Suggestions of Independence.*—Most hysterical and nervous patients, broken down in will as they are, require a mental splint, which the physician can supply by strengthening suggestions. There comes a time, however, when the patient must be discouraged from relying upon the moral support of the physician, and must be stimulated to exercise his own independence of will and character. If such independence is always established, there will be no reason for the objection, so often raised against treatment by hypnotic suggestion, that it weakens the will of the patient, an eventuality I have never known to occur during seven years' experience.

Auto-suggestion.—Therapeutic auto-suggestion consists in the patient himself inducing a condition of relaxation of body and mind, as in hypnoidal suggestion, and then summoning up healthy ideas, one after the other, and dwelling upon them for a time so as to allow them to "soak in," until they bring about a healthy state of mind. That, at least, is what is supposed to occur, according to the books. What actually happens in most cases is that the mind in this relaxed condition becomes occupied with the morbid thoughts which it is trying to get rid of; thus the patient is merely suggesting these to himself, and his last state is worse than his first. The remedy for this is very simple, and consists in instructing him to think over the proposed healthful suggestions beforehand while he is still fully awake. Thoughts prepared and projected in this way will naturally recur to him when he is in the hypnoidal condition, and the morbid thoughts will no longer intrude. By this very simple precaution a well-meant but harmful practice may be turned into one of the most valuable aids to psychotherapy.

Collective Hypnosis.—A famous psycho-analyst has remarked that the poor have no right to psycho-analysis.

But as long as the poor suffer from neuroses it is the duty of the medical profession to treat and to cure them. There is one method that is able to cope with the task of treating large numbers of such patients—viz., collective hypnotic suggestion.

Let me outline this method as I practise it in a ward of "shell-shock" patients. About twenty to twenty-five patients are hypnotized at once, lying on their beds or comfortably seated in armchairs in a large room. General suggestions of relaxation and repose are sufficient to send a certain proportion of them to sleep. I then pass round to each patient in turn and, by fixed gazing, hypnotize them all. So far the proceedings take about ten minutes for twenty patients. When they are all hypnotized, "tonic suggestions" suitable to the condition of all are given to the clinic generally—"hopefulness," "confidence that they are going to be cured," and others of a stimulating kind. After general tonic suggestions, "specific suggestions" are given individually, suitable to each man, whether his condition be that of paralysis, aphonia, nervous anxiety, obsessions, pain, or weakness. These are followed by general suggestions of vigour for the day's work and of a quiet, restful night's sleep.* Every patient, after he has been in the general clinic two or three times and been thus familiarized with the routine methods of hypnosis, is taken into my room and there thoroughly examined by hypno-analysis, in order that the cause of his condition may be discovered. The analysis is usually completed on a single occasion, but sometimes needs to be repeated. After their repressions have been discovered, they return the next day into the general clinic, there to be treated by reassociation with the suggestions suitable to their condition, until their mental equilibrium is established. I give them treatment daily for the first week, and three times a week afterwards,

* I never find it necessary to give any kind of hypnotic drug to any patient when he has once started to receive treatment under collective hypnosis.

extending over three or four weeks. Some cases, however, require two or three months' treatment before one can feel justified in sending them out to their employment.

The advantages of collective hypnosis are so great that I venture to summarize them: (1) It enables us to treat a large number of patients at once in the minimum of time, the collective treatment of twenty patients requiring about forty minutes daily, exclusive, of course, of the single treatment by hypno-analysis for each patient in my private room. (2) It tends to encourage that "curative atmosphere" which is found to be so valuable in all suggestive treatment. (3) It enables us to hypnotize patients very easily, for the suggestion of twenty men around in a condition of sleep is powerful enough to put a new patient to sleep almost without further encouragement from the physician. The results I have already recorded, which showed that sixteen out of seventeen patients became analgesic, are much more satisfactory than I could have obtained by treating the patients individually.

One of the patients, being treated for insomnia, expressed the influence of the collective hypnosis in these terms: "On the occasions when I have been present at collective hypnosis there appeared to be a much stronger effect than when I was treated privately. The feeling I had on these occasions was, that the air was charged with sleep, and that drowsiness poured into one from all quarters instead of from one point only as in solitary treatment." The same increased effect is produced by the curative suggestions. Collective hypnosis is, therefore, to be strongly recommended, not only from the point of view of organization and economy of time, but also for its more potent therapeutic effects.

TREATMENT BY PERSUASION

The word "persuasion" is a clinical rather than a psychological term. It should signify the form of treatment which appeals to the conscious reason and enforces its claims on logical grounds; but in actual practice the success of persuasion depends on suggestion, especially that derived from the authority of the physician and the expectancy of the patient, as has been pointed out. We have watched physicians successfully cure patients by bringing forward explanations and logical arguments which obviously greatly impressed them, but of which, just as obviously, they understood scarcely a word! Persuasion is, however, a useful clinical term, for it signifies the combination of the two methods of logical appeal and waking suggestion. It differs from hypnoidal and hypnotic suggestion in that it is carried on entirely in the fully waking state. It means discussing with the patient the origin and causes of the complaint with absolute frankness, reassuring him as to its curability, readjusting his mental attitude, and re-educating him in the use of lost or perverted functions.

The treatment by persuasion is employed daily by every physician who encourages or admonishes his patients, but it needs to be used systematically if the best results are to be secured. Those who have not employed it in this way cannot realize the extraordinary results which may be obtained: complete functional paralyses, aphonias, contractures, spasmodic movements, and severe pains can be cured by simple conversations rightly directed, sometimes in the course of one sitting.

At the present stage it is scarcely possible to define exactly which cases we should treat by suggestion as described elsewhere, and which by persuasion, and in actual practice we use both methods in almost all cases. But persuasion is most effective for treating the "conversion

neuroses," such as the paralyses just mentioned, while the more generalized nervous conditions are best treated by suggestion. In other words: where the patient's will is strong and his self-control well established (except for the local hysterical disorder) persuasion is more useful: but where the patient has lost his self-control, where there is emotion or amnesia, suggestion is to be preferred. In those cases where a suppressed emotion is combined with a local hysterical symptom, where, for instance, a man who has been buried develops paraplegia with night terrors and headaches, we begin with suggestion to cure the emotional condition, and then proceed to re-educate his limbs by persuasion.

The simplest way of demonstrating the method of persuasion will be to create a "psychopathological man," very much as the old economists created the "economic man." He is a "shell-shock" patient; as a child he was self-conscious and oversensitive; as a young man he was introspective, apt to brood and "take things to heart." In France he was buried by a high-explosive shell, and afterwards suffered from general nervousness, bad dreams, headaches, weakness, and had complete amnesia of the incidents of his burial. He carried on until he was wounded in the arm by the explosion of a gas shell, and was taken to hospital suffering from the wound and also from vomiting, aphonia, laryngitis, and from pain in the parietal region. After the wound was healed there was a contracture at the elbow joint, with severe pain on attempting to move the arm; but he was also found to be suffering from a flaccid paralysis of the hand, with anæsthesia.

Using this composite "psychopathological man" as an illustrative case, the following are the methods of persuasion which might be employed to bring about the cure:

Reassurance.—We discover by a thorough physical examination that the contracture, now that the wound is healed, is hysterical in character, that the anæsthesia of the forearm is not of an organic type, and that there is no

lesion to account for the flaccidity of the hand. The examination of the vocal cords shows only slight swelling; and there is no fracture of the skull. As the physician proceeds with his examination, the patient's interest and suggestibility are aroused by hints as to the meaning and result of the tests. He is finally *reassured* in confident words that the condition is quite curable.

Elucidation.—(a)* As to the *predisposing causes* of his breakdown. He is shown how his self-consciousness and introspection have rendered him more sensitive to the darts of ill-fortune. It may be necessary to make a psycho-analysis along the lines described in another chapter, to which the reader is referred.

(b) Mental Anxiety.—The theory of repression will be explained in simple terms, and the patient will be shown how the dreams of the night originate in the repressions of the day: how his weakness is due to emotional conflicts which sap his strength; and how the anxiety of his mind produced the headaches. He is therefore encouraged, not to try to forget his painful experiences, but to speak freely of them, face his difficulties, and even recall, if possible, his amnesia. This can sometimes be done by conscious persuasion alone, but more easily and effectively by hypnoidal or hypnotic suggestion.

(c) The pain in the arm, especially on movement, will be shown to be due to the old association in the mind between contracture and pain, which lingers on after the wound has quite healed. Or it may be explained that, while originally it was the pain of the scar which necessitated the contracture of the muscle, subsequently it is this spasm of the muscle that produces the pain, as in "cramp." *The pain in the head* is found to be due to a sympathetic cause, for when the shell exploded, the patient saw his mate struck on the head and killed by a piece of the shell. A similar sympathetic pain was felt by a patient of mine who had severe abdominal

* The following points in ætiology are not intended, of course, to be exhaustive, but are merely taken for illustration.

pain whenever his wife went into labour. Many a pain disappears when the patient "knows what it is," and the emotional element is withdrawn from it.

(d) *The contracture* is shown to be due to a defence mechanism, originally designed for the purpose of avoiding the pain of the septic wound. It is explained to him how the contracture, originally voluntary, has now become involuntary and persistent.

(e) *The flaccid paralysis* of the hand is explained as due to the numbness of the protective anæsthesia which suggested cold and therefore loss of function. The patient has now forgotten how to use the muscles, although nothing is organically wrong with them. There is a break, if one may put it crudely—and a crude simile is often most successful with a lay patient—between the will and the brain cells, so that, though the will is exerted, no voluntary action follows. Only by exercise and continued exertion can the channel which has become blocked be opened again for the energy to pass down the limb.

(f) *His vomiting* also persists as an associate symptom from an original gastritis due to swallowing the gas. The gastritis has disappeared, but the vomiting persists. The *aphonia* persists as a result of medical suggestion from his physician, who said that he must "take great care of his throat," an injunction most necessary when he had acute laryngitis, but now only perpetuating the aphonia. The *difficulty in swallowing* is due to the interference of the conscious volition and attention into a process that should be automatic: this is a most fertile cause of many hysterias and disturbances of circulation, alimentation, and secretion. It is observed that it is the opposite process of the contracture, which was due to a voluntary movement becoming involuntary. In the case of swallowing, the process, which should remain reflex in the lower centres of the brain, has invaded consciousness; in the other, a conscious voluntary action, contractive, has become habitual and automatic.

Demonstration.—Verbal explanation may not appeal to

the patient, where demonstration to his senses will be convincing.

(a) It is demonstrated that a rigid contraction of his sound arm against resistance will cause pain in his muscles, and he is reminded of how pain may be produced by a cramp due to muscle spasm; the pain in the wounded arm, he is told, will disappear when he leaves his arm easy and does not contract up his muscles, and the fact is demonstrated to him little by little with the injured arm.

(b) It is further demonstrated from his sound arm that by forcibly contracting the opposing muscles he produces both rigidity and tremor; to illustrate this he is told to make his sound arm stiff—i.e., to contract the opposing muscles; while he maintains this “stiffness” even the exertion of his will cannot overcome the contraction.

(c) His flaccid hand is shown to be capable of movement by the application of an electric current, proving that nerves and muscles are organically sound.

(d) A great deal can be done by demonstrating the inconsistency of the patient's symptoms—e.g., that a tender spot is not felt to be tender when the patient's mind is absorbed in other things: his attention is suddenly called to the fact that the physician is pressing hard on the spot without his being conscious of any pain. Or, a patient who cannot bend his arm when he voluntarily tries to do so will be found bending it in order to raise himself from the bed. He is shown that, while he cannot phonate when he tries to speak, he does so when he coughs, so that the function is not really lost. It is particularly necessary that the physician should point out such inconsistencies without the slightest suggestion of “catching” or “detecting” the patient, for otherwise, instead of curing him, the demonstration merely makes him determined not to be caught again.

Re-education.—By this time the patient is probably either cured or is ready to give the treatment a fair trial.

(1) The contracted arm. The patient is taught to relax

all the muscles of the contracted arm while the physician kneads the muscle and suggests relaxation. When this is proceeding satisfactorily, the limb is gently flexed and extended, and it is pointed out to the patient how little pain he gets when he leaves the limb slack in the hands of the physician and complete relaxation is achieved. The patient is then taught to contract the muscles alternately, first the flexors and then the extensors—these muscle contractures being first demonstrated on the sound limb—until complete control of the injured limb is secured, sometimes in a few minutes, sometimes in a few hours.

(2) The flaccidity is dealt with differently. As the condition is due to a “block” between the will and the muscles, the patient is taught to do simple movements which he has “forgotten,” by exercising each finger, then the finger and thumb, and finally the whole hand. This at first requires an effort of will, but slight improvement will encourage the patient to persevere cheerfully.

(3) His vocal cords are re-educated by making him cough vocally, and then to cough out definite letter sounds, beginning with vowels. Two minutes is sometimes sufficient to cure an aphonia of months’ or years’ duration.

Examination and Reassurance : Elucidation : Demonstration : Re-education.

Such may be taken as typical methods of treatment by persuasion, but it is obvious that the physician will frequently need to have recourse to his own ingenuity in devising methods to combat the varied symptoms which present themselves.

CHAPTER VI

REPRESSION AND SUPPRESSION

BY W. H. R. RIVERS, M.D., LL.D., F.R.C.P.

Prefector in Natural Sciences, St. John's College, Cambridge; Formerly Medical Officer, Military Hospital, Maghull; Medical Officer, Craiglockhart War Hospital; Psychologist, Central R.A.F. Hospital, Hampstead.

(a) RECOGNITION OF SYMPTOMS.

Repression. The attempt to banish from consciousness a part of itself—Suppression. The process by which some part of conscious experience is placed outside conscious recollection.

Association of Instinctive Tendencies.

Instinctive tendencies which demand suppression: (1) Those which would promote happiness but are in conflict with traditional standards. (2) Protective tendencies whose purpose is to avoid danger.

Anxiety State.

Produced by reawakening into activity of suppressed tendencies and experiences—Type of neuroses differs according to nature of tendencies—In civil life, chiefly those in conflict with social standards, and frequently connected with sexual needs—In military practice, protective tendencies.

Reawakening of Protective Tendencies in Soldier.

Cause of failure of suppression—(1) Excessive strain of inactive exposure to constant danger—(2) Insufficient training—In face of danger: (a) Cases where suppression fails on first exposure to danger; (b) cases where suppression sufficient excepting after fatigue and strain. Effect on the mind: The vicious circle. Failure of suppression calls conscious repression into play. Repression of fear and manifestation of fear increases fatigue, so weakens resistance, and repression becomes more and more difficult. The obsession: This tense anxiety state tends to centre round some particular painful experience.

Nature of sleep a factor in diagnosis. Unsatisfactory sleep : (1) Due to repression ; (2) causes additional fatigue—link in vicious circle ; (3) gives opportunity for repressions to (a) emerge into consciousness ; (b) find expression in painful dreams. Dreams : (1) Reproduction in detail of painful experience ; (2) symbolic and dramatic form of repressed experience—Both forms of dreaming frighten—add fatigue, and so link in vicious circle—Effect on physical, intellectual and emotional life—Physical : Interrupted digestion, circulation, fatigue. Intellectual : Loss of attention, memory, capacity for work. Emotional : Loss of interest in life, friends, etc.

(b) TREATMENT.

Release of Repression.

Breaking of vicious circle : (a) Strain of dreams will vanish or be lessened. (b) Sleep become peaceful, mental strength acquired. Convince patient of harmfulness of repression.

Habitual Repression.

Cases where process of repression has become automatic and patient believes it right—Advise patient to beware of unconsciously banishing or dwelling too intently on recalled repression.

(c) REACTION TO TREATMENT.

Depends largely on intelligence and mental plasticity of patient—Cause of success : (1) Cessation of repression ; or (2) suggestion that cessation of repression will bring about cure. Military experience favours success due to cessation while not minimizing value of suggestion in treatment.

(d) VOLUNTARY REPRESSION.

The ability of voluntary repression to produce suppression and dissociation often questioned—Investigation has proved it possible in some cases.

(e) REPRESSION AND THE ORGANIC FUNCTIONS.

Extent of influence of repression on organic functions.

THE term “repression” will be used here for the process by which an attempt is made to banish from consciousness some part of its content, whether this be a thought, memory, or emotional tendency. It is to be distinguished from the process of “suppression” in which some part of the mental content is so separated from the general body of conscious experience that it is never recalled to consciousness by the ordinary associations of waking life, though it can be

brought to the surface by special means, such as hypnotism, or may appear, though usually in a disguised form, in dreams. The experience which is thus suppressed is closely associated with instinctive tendencies, the suppression becoming necessary through the incompatibility of these tendencies with acquired standards of thought and conduct.

The instinctive tendencies which thus need suppression, and in being suppressed carry with them such experience as may have been associated with these tendencies, are of two chief kinds. In some cases the tendencies and associated experience which call for suppression are such as promote the immediate happiness of the individual, but are in conflict with the traditional standards of thought and conduct of the society to which the individual belongs. In other cases the tendencies which need suppression are of a protective character. Their function is to produce immediate pain as a means of warning against and avoiding danger. Suppression tends to occur when these protective tendencies produce reactions in excess of the needs.

Neurosis depends primarily on the partial reawakening of these suppressed tendencies with their associated experience. When thus reawakened into activity, the suppressed experience comes into conflict with conscious states and produces a state of anxiety which forms the leading characteristic of the neuroses now to be considered.

The neurosis of war differs from that of civil practice chiefly in the nature of the suppressed tendencies which are reawakened. In civil practice the instinctive tendencies which are recalled into activity belong predominantly to the first of the two kinds described above—that is, tendencies promoting the immediate happiness of the individual, which have been suppressed because they are in conflict with social standards. In many cases the tendencies thus reawakened and the associated experience are connected with the group of instincts concerned with sexual needs.

In military practice, on the other hand, the instinctive

tendencies which are rearoused belong predominantly to the second kind—that is, those which have a protective character. The life of a member of a modern civilized community rarely presents any situations which tend to reawaken the group of instincts by which the individual is protected from danger. During childhood his training is directed towards the repression and suppression of any signs of fear, and the dangerous situations which are encountered by the normal healthy man are neither sufficiently intense nor persistent to make any great demands on the suppressed tendencies. The frequency of neurosis in the recent war is partly due to the excessive strain of modern warfare, especially of trench warfare, in which the soldier is exposed to the utmost dangers without being able to carry out activities by which these dangers can be met. The other leading condition of the frequency of neurosis in the war is that the great majority of those who have taken part in it have had in very insufficient measure the training by which the repressions and suppressions of the professional soldier are strengthened.*

In some cases of anxiety-neurosis the suppression of fear has been insufficient from the first encounter with danger. In other cases the suppression only becomes inadequate as the result of fatigue, strain, exhausting illness, or shock. In either case conscious repression becomes necessary whenever suppression fails. It becomes necessary to repress the fear which shows itself, while it is still more necessary to repress the manifestations of fear by which its presence may become apparent to others. When the failure of suppression is due to fatigue or strain, the efforts necessary to carry out repression greatly increase these states, and by thus weakening still further the controlling and suppressing forces set up a vicious circle in which the need for repression and consequent strain becomes still greater.

* See W. H. R. Rivers, "War Neurosis and Military Training." *Mental Hygiene*, 1918, vol. ii, p. 513.

The necessity for control is especially great in the case of the officer upon whose composure the *moral* of his men depends. It is in his case, especially, that the conflict is apt to become so severe as to set up a persistent anxiety and dread of a definitely pathological kind, differing both in severity and quality from the anxieties of health. This anxiety tends to centre round some painful experience, which may be of long standing or of recent date, or it may take as its nucleus some recent worry or other emotional state. The experience which thus stands out in consciousness is viewed in colours far blacker than its nature justifies, and becomes so painful and apparently unendurable that the patient strives with all his power to banish it from his mind. The efforts required for this purpose make a great demand on the mental activity of the patient, and only increase the fatigue and strain which already form the chief conditions of his illness. The increased strain enhances the severity of the conflict which is already present, and thus accentuates the anxiety of the sufferer so that still stronger efforts of repression become necessary if the painful experience which tends to dominate the mind is to be kept from consciousness. This form of repression reinforces that already present through the awakening of fear and its expression, and thus adds to the vicious circle by which the morbid state of anxiety is maintained and enhanced.

The group of symptoms so produced is now usually known as anxiety-neurosis, a complex state with many and varied manifestations. As soon as the reawakening of the suppressed tendencies and experience begins to raise a conflict, there is interference with the normal sense of well-being, and this disturbance grows in strength and persistence until the patient is dominated by a dread which meets him in whatever direction he may turn his thoughts or activities, a dread which naturally leads to depression. In some cases the dread and depression seem to have no cause, or none which even the patient himself can recognize as adequate. In other cases a process of rationalization

leads him to choose some special aspect of his experience, or even some special incident, as the cause of his trouble.

So long as the anxiety and loss of well-being are slight, it may be difficult to distinguish between the effects of mere fatigue and strain and those due to a mental conflict. The most useful sign is the nature of sleep. So long as the state is one only of fatigue, sleep is not disturbed and is refreshing, but if mental conflict between suppressed and conscious experience is present, sleep becomes light. The patient takes long to get to sleep or wakes early, and such sleep as he obtains is disturbed by dreams and does not refresh. In other cases he continues to sleep with apparent soundness, but wakes in the morning unrefreshed, so that he begins the day feeling more tired than when he went to bed.

The insufficient, disturbed or unrefreshing sleep increases the fatigue, and thus adds other links to the chain which makes up the vicious circle of his state. At the same time the wakefulness when he goes to bed or in the intervals of sleep gives an opportunity for the anxieties, painful thoughts and memories which have been kept out of sight, either by the interests of the day or by the process of conscious repression. Assisted by the silence and solitude of the night, the repressed elements of the mental content are too much for the lowered powers of control, and the painful experience emerges into consciousness with far more insistence and in even more painful aspect than it would have borne if it had been faced in the light of day. When sleep at last arrives, and the control of the waking state is removed, the repressed experience finds expression in a dream, with a peculiarly painful and distressing quality which is unknown in the waking experience of the healthy person. The dream may take several different forms. In one, especially frequent after the excessive strains and shocks of warfare, some painful experience is reproduced in all its detail, but accompanied by an emotion far surpassing in strength any experience of the waking life, and the dreamer wakes with the characteristic expression of the emotion

which dominates the dream. If this be fear, he is cold and bathed in sweat, his heart is beating violently, and when observed by another he is seen to be showing the facial expression and tremor which are characteristic of fear. If the dominant emotion of the dream be grief, the sleeper awakes sobbing and with his eyes streaming with tears.

More frequently the content of the dream is not a reproduction of an actual occurrence, but the patient's anxieties, painful memories, or other repressed experience, find their expression in a dramatic and symbolic form, often differing so widely from the symbolized experience that the patient wholly fails to recognize the relation between the two. Whether the dream be a reproduction of actual experience or have a symbolic character, it possesses for the patient a mysterious and terrifying quality which continues to dominate his thoughts during the day, adding greatly to the strain and fatigue, and thus forming still another link in the vicious chain. In some cases the memories of the dream are so distressing that the patient is afraid to fall asleep, and adds to his causes of exhaustion the voluntary curtailment of his sleep.

The chain of events will not have proceeded far along its course before other signs of the conflict show themselves. The organic systems of circulation and digestion, etc., may be upset, and so contribute other and more physical elements to the morbid agencies of the disease. The conflict alone would be sufficient to depress the power of attention and the capacity for physical and mental work, but this depressing action is greatly enhanced by the loss of sleep and the impairment of organic function. The patient becomes unable to read more than a page or two of a book, and fails to remember what he has read. His memory for recent events is impaired, and he is fatigued by an amount of exercise which in health would be merely stimulating.

Still more trying than these changes in the physical and intellectual spheres are those on the affective or emotional

side. He loses all his interest and zest in life. His feelings of affection for relatives and friends are dulled or may even be replaced by dislike. Intercourse with his fellows, even with those nearest and dearest to him, becomes an effort often beyond his powers. If the disturbance reaches this extent there will be great diminution or even complete loss of sexual desire and power which, combined with his altered feelings, may increase the depression, while the domestic situations which these symptoms produce often introduce new sources of distress and anxiety.

Treatment.—In the complex web of agencies upon which the state of anxiety-neurosis depends, a most important part is taken by repression. This process is of especial importance from the therapeutic point of view, in that it affords a good point of attack by which it is possible to break the vicious circle in which the morbid process is being maintained or is even growing in severity. For, being a process which depends upon the voluntary efforts of the patient, it is more amenable to influence than the other agencies upon which the disease depends. If the patient can be induced to give up the repression, there is usually an immediate effect upon the dreams. In the most favourable cases they may cease altogether, but more frequently they lose their distressing quality and cease to awake the patient, or he awakes without the terror, horror, or other emotion which has dominated his dream and without the physical expressions of his emotion. If he becomes able to go to bed in comfort and in reasonable anticipation of peaceful sleep, one of the most potent agents in the maintenance of his illness will have been removed, and an opportunity given for the organic functions, the disturbances of which are helping to maintain the disease, again to recover their normal balance. The patient will then gradually reacquire the mental strength which will enable him to face any real anxieties or worries which cannot be removed.

In order that the patient shall give up the process of repression, it is necessary to convince him of the harmful nature of the process. Often, as soon as the nature of his behaviour is pointed out to him, he recognizes its futility, and is at once ready to face his trouble. Sometimes, however, even in those who recognize this futility, the repressed experience is so painful that it cannot be faced, and in such cases much can often be done if it is possible to find some aspect of the painful experience which shows it in a new light, perhaps even in a pleasant light, and so makes its contemplation possible.*

In other cases repression may have become so habitual that the patient finds it difficult to give it up, or the process may have become so firmly fixed and so automatic as to have passed beyond his control. In still other cases, the act of putting away the unpleasant seems to the patient so natural a thing to do that it is difficult to persuade him of the opposite, and this reluctance is often strengthened by the previous prescription to repress which has been given to him by his friends or his medical advisers. The most useful argument in such cases is that, since the many other remedies which the patient has tried have failed, he should at least give a trial to the new measure, in spite of its unpleasant nature. The most difficult cases are those in which the patient does his best to face his trouble, and perhaps even thinks about it more than is needful, but nevertheless unwittingly thrusts it from his mind at times, and especially at night, when the prospect of a dream recalls the habit of repression. In this and other cases it is necessary to point out to the patient that it is not required that he should dwell upon his troubles or attempt to recall them when they are not present, but only that he should not attempt to banish them if they appear. It is often well to say that dwelling upon distressing thoughts is as noxious as repression, and that what is needed is the

* For a good example see *Proc. Roy. Soc. Med.*, 1918, vol. xi (Section of Psychiatry), p. 6.

middle way between the two extremes of obsession and repression.

The success of the treatment is conditioned largely by the degree of intelligence and mental plasticity of the patient. In military practice there is a striking difference in the results of treatment between officers and men, which is certainly due to the difference in intelligence and plasticity which on the whole distinguishes the two groups. The one will see at once the rationale of the treatment, while the other may require examples and parallels from other aspects of life more familiar to him than his own mental processes before he can be persuaded that the immediate comfort of escaping from the painful has to be paid for, and at a heavy rate of interest, later.

In this, as in every other therapeutic problem, the question arises whether the success which follows the advice to give up repression is due to the cessation of repression or is the result of suggestion. The military experience that success is greater with officers than with men is strongly against the view that the improvement is due to suggestion. There is little doubt that the private soldier is more suggestible than the officer, and if suggestion were the main therapeutic agent, we should expect the private to improve the more quickly.

If we refuse to accept the greater suggestibility of the private soldier, the advocate for suggestion is still confronted with the need of explaining the difference between the two classes of soldier. Such a symptom as a war-dream must certainly have the same pathology in the private as in the officer, and the difference in the therapeutic effect must be explained by something in the nature of the reaction to the treatment. The influence of suggestion cannot be excluded, and in some cases probably plays a not inconsiderable part, but the available evidence is strongly against its being the chief therapeutic agency. The facts point to the cessation of repression as the chief condition of success, and to this success as due to the removal of an agency by

which the dreams have been produced and are being maintained.

A question of some importance is whether voluntary repression is capable of producing suppression and dissociation, and consequently, lapses of consciousness, automatic actions, fugues, and other manifestations of dissociation. The investigation of cases of this kind usually brings out the presence of repression, often in a pronounced form, and when repression is discontinued the dissociated states often cease to appear. There is therefore much reason to believe that repression leads to dissociation, especially in persons disposed to this process, and that cessation of the repression is followed by disappearance of the symptoms dependent on dissociation.

A more doubtful question is whether the disturbances of organic function which characterize anxiety-neurosis are due to repression, or are only influenced by it secondarily through the action of repression in maintaining and accentuating the anxiety state. Improvement in these organic disturbances frequently follows the cessation of repression, but it is more gradual than the effect on dreams or dissociated states, and is probably due to the diminution in the gravity of the state of anxiety which follows the removal of the disturbing and distressing symptoms dependent on repression.

CHAPTER VII

REGRESSION

BY MAURICE NICOLL, M.B., M.R.C.S.

Formerly Medical Officer, Empire Hospital for Officers.

ANALYSIS OF THEME.

The significance of Regression :

1. Psycho-analytic Basis.
2. Neurotic Relapses.
3. Neurological Aspect.

1. THE PSYCHO-ANALYTIC BASIS.

Regression, problem connected with inherent dynamics of human psyche, a movement from adaptation back towards infant security—Failure of adaptation results in (1) Arrest of normal forward movement ; (2) the formation of new symptoms ; (3) consequent continual sacrifice of the future at expense of more suffering.

Regression and the Complex.

Three methods of coping with intolerable situation : (1) Normal adaptation by progression ; (2) quasi-adaptation by repression ; when successful, only potentially neurotic ; (3) regression (extreme repression), accompanied by pathological suffering—Regression, psychic movement inwards, away from reality towards phantasy consciousness—Nature and degree of movement varies—All regression means impoverishment of adaptive life.

Regression Movement Illustrated.

Mother motif goal, incident in theme of myths, impossible as resting-place, satisfying only half of man's innate psychic tendencies—Similarly, paradise motif, state of happiness in which man takes refuge in unconscious phantasy. Illustrative dream.

2. NEUROTIC RELAPSES.

A form of regression frequently encountered during treatment—Significance not confined to symptoms—Fluctuation illustrates mechanical aspect, “the revival of former mode of reaction”—Any required effort may be indirect cause—Necessity of considering relation of revival of symptoms to confront problem. Dynamic psychological view proffered—Adaptation to small tasks essential to cure—Neuroses regressively animated when recovering neurotic fails so to adapt. This reanimation due to energy diverted from adaptation inwards to revival of former mode of reaction—Cause, therefore, in existing circumstances—Primary importance of the peculiar personal attitude to obstacle.

Analysis of Inner Psychological Disabilities.

Personal attitude dependent on inner psychological factors requiring analysis : (1) Special disabilities ; (2) pre-existing conflicts, due to personal development ; (3) psychological type—It is these inner psychological disabilities which magnify difficulties and make adaptation problematic.

3. NEUROLOGICAL ASPECT.

Relation of neurological standpoint to Hughlings Jackson's teaching on dissolution in nervous system. He emphasizes fact that : (1) Destruction of nervous tissue cannot produce positive symptoms ; (2) symptoms due to activities of non-pathological nervous elements—This observation not sufficiently widely acknowledged.

Jackson's Teaching and Modern View.

- (1) Dreaming, primitive way of thinking, mode of psychical activity which in regression of normal sleep is reanimated ;
- (2) to understand dreams and their method of representation seek parallels in myths, legends, etc.—The analogy between organic state of partial dissolution of first level of nervous arrangements and the anxiety state of partial psychical regression.

I

THE significance of regression will be treated in this paper under three headings : (1) From the psycho-analytic standpoint, as a problem connected with the inherent dynamics of the human psyche ; (2) from the standpoint of neurotic relapses ; (3) from the neurological aspect.

Regression is a psychic act and, in the broadest sense, is a movement away from the adaptations of life back towards that condition of security which the infant experiences in

its mother's arms, before it has discovered the responsibilities of this world. It is a movement towards the "mother." This movement is a psychical one, ontogenetic in character, and though we cannot help thinking of it in terms of space and direction, it is more properly to be conceived of in terms of time and attitude.* In place of meeting fresh obstacles in life by achievement, the neurotic forms fresh symptoms. The forward movement that accompanies the overcoming of new tasks is absent, and in its place something is substituted that appears on the surface to be merely an increased production of barriers. Giddiness is added to anxiety; headaches, nausea, palpitation, numbness, and a host of other disabilities reveal themselves. The future is thus sacrificed continually, at the expense of more suffering, and the forward movement of normal life is arrested. In such cases we are tempted to say that the patient prefers his neurosis to health. There is no doubt that such an impression is a common one during analytical treatment. Patients frequently seem unable to give up their symptoms—at times they even seem to cling to them doggedly, although consciously they declare they long to be well. Something very powerful drags them down and holds them fast in the grip of the neurosis. But this is an extraordinary statement to make, unless it is given some explanation, for no human being prefers suffering to health. It would appear that the psychic stream in neurotics had found another goal which is certainly quite different from that towards which a healthy individual strives.

There are three main ways of escaping from an intolerable situation—apart from running away: (1) The overcoming

* This *motif* is constantly found in dreams. Freud conceives of the "longing for the mother" in the physical sense only—as the objective mother, and so he postulated the existence of the "incest-wish" in every individual. The longing for bliss, for peace, for the ideal, may be put in concrete terms in the dream as a mother-wish, but it transcends the objective implication. Jung broadens the conception and puts it on a psychological level (cf. "Psychology of the Unconscious," especially Chapter on "Sacrifice").

of the situation by a forward-striving effort, accompanied by normal suffering. This is adaptation by progression and is normal and non-neurotic. (2) The temporary overcoming of the situation by repressing some part of emotions which it arouses. This is quasi-adaptation by repression. Provided the repression is successful, it is only potentially neurotic. When there is a partial failure in repression, conscious control is seriously interfered with, and normal adaptation to the tasks of the day becomes impossible.* (The more evolved and sensitive the individual, the more inclined is he to repress, but the less likely is it to answer. Successful repression seems less easy for humanity to-day than it was formerly.) (3) Where the character of repression is extreme it amounts to regression, and in this case normal suffering is replaced by pathological suffering. This method is the exact opposite of adaptation by progression, the psychic movement being inwards, away from the level of reality-consciousness, towards a level of phantasy-consciousness. The movement may be slow or sudden; it may be arrested early or it may go so far that the patient becomes blind, deaf, dumb, and quadriplegic or psychically infantile, or both.

All regression, of whatever degree, means some impoverishment of life—that is, of the focussed adaptive life of a normal being. The soldier in the trenches who becomes functionally paralysed renounces his daily life for the time, and withdraws from it by a psychological path. *He does not run away from it physically, but psychically, and the path that is open to him is that of the retracing of his ontogenetic development.*† The following case illustrates the movement of regression :

CASE 1

The patient, an officer aged twenty, was taken prisoner

* For the best English presentation of Freud's teaching on Repression see Ernest Jones, "Papers on Psycho-Analysis." 2nd edition.

† In dreams the dreamer is often younger than he actually is—sometimes he goes back to school, sometimes he is a little boy, etc.

under doubtful circumstances. He escaped and was interned. Shortly after he began to lose his sight, hearing, and speech. The conversion of his conflict into the somatic sphere was of the ingravescent type. There was no sudden conversion. Both legs then became slowly affected, and both arms. The right arm, however, recovered soon. Sight, hearing and speech were lost. His condition remained stagnant for many months. When I saw him he could move his right arm freely. His expression was placid and meditative. Transference was obtained with difficulty, but once established, he spoke a little. He seemed, psychologically, about twelve years old. During the next three weeks the regressive movement continued until he was psychologically five years old or thereabouts. He called the servants by the names which had belonged to servants who had been in the house when he was five. He called his young sister by the name of his eldest sister, etc. His speech was infantile. He lisped and used phrases and recalled incidents that his mother remembered only with difficulty. He remained at this level of regression for about two weeks. The transference was now very strong, and he slowly "grew up" until he was about seventeen. Here he came up against the periphery of his war experiences, and the progressive movement in his psyche was held up again, there being total amnesia for the war. He had now recovered his speech, his hearing, and his sight, but the left arm and the legs remained paralysed.

In this patient the impoverishment of life was complete, showing that the conflict, which he sought to solve by regression, was profoundly painful.* The method whereby

* I have given a partial history of this case in rough outline only. The nature of the conflict has been hinted at. The patient was very intelligent, with high ideals, but had always found the problem of physical danger acutely difficult. He played games in order to overcome his fear of them, not because he liked them. The following dream, that he had when on the upward path and had reached the age of about two years old, may be of interest to some: "It was a very beautiful sky with the sun shining and birds flying about, and nice fleecy clouds sailing along, but underneath somewhere was a cellar, very dark, with a ladder going down, and at the

he solved his problem was pathological. He solved it at the expense of his normal efficiency as an adult being, substituting for the adult relationship to life a relationship that was increasingly infantile,* and freeing himself from the anxiety that inevitably arises as regression proceeds, and the forbidden barrier is approached, by converting it into an extensive somatic palsy. It was only toward the end of his return to normal life that anxiety began to appear—that is, when the somatic conversion was lifting and the converted affect was reappearing in the psychical realm.

CASE 2

The patient, aged twenty, a flying officer, crashed and was concussed. Previous to this, his history was as follows: He had crashed twice before in the previous month, and had suffered no physical damage, but his nerve was badly shaken. He began to get feelings of anxiety, became rather sleepless, and had one battle-dream. He took to drinking and carousing in general as a relief.†

A short time later the third crash occurred and he was stunned. On recovery, a severe anxiety-neurosis developed, with hallucinations (not only hypnogogic, but during the

bottom of the ladder was a box which had something in it that I had to get, but it was too dark, and I don't think I could get down the ladder." Taking the dream from the aspect of subjective (functional) symbolism, it represents, in analogy form, his psychological situation, from the point of view of his unconscious thinking. The regressive mother-motif is contained in the first part. The progressive reality-motif is contained in the second part, where the task to be faced—the recovering of his normal psychic content—is shown in sombre contrast to the psychological mother-motif.

* The instinctive expression, "Don't be a baby," contains a true psychology.

† Regression had begun. The task of flying became increasingly formidable, and a psychic retreat from it began, with a rise of anxiety. He endeavours to blot out reality by alcohol. From my point of view, whenever the battle-dream begins, the balance has begun to be tilted and regression has set in. The normal direction of the psychic stream has been partly reversed, and the regressive movement preponderates. A pathological condition is therefore present.

day), battle-dreams, giddiness on rising from the recumbent position, suspicion and childishness. Transference to me was very difficult to obtain, but went spontaneously to a large motherly nurse who attended him. At the same time he regarded a young and pretty nurse, who also attended him, with suspicion, and accused her of "pretending to be someone else." He was extremely difficult to treat, his infantility being so pronounced that he was as much a tyrant as a baby. On Christmas Day he wore a paper hat and insisted on wearing it for many days later, blushing when I called his attention to it, but refusing to give it up. He demanded food every two hours or so. Any show of sternness made him worse, and he would then wander in his speech, say strange things, and roll his eyes in a manner that alarmed his attendants. The dreams were continually dealing with his infantility. He would dream, for example, that he was walking about with a very small child about five years old. He had to look after it, and was impeded by its presence.* The hampering child is his own hampering

* At a later stage, when he was recovering, he had the following dream : He witnessed "two snakes fighting in a tall room. They were each about six feet long. One was green and the other black. For some time the fight seemed equal, and then the black snake killed the green one, winding itself round it and crushing and biting it. Then the black snake seemed to be wound round my leg from the thigh down to the foot, and its head was biting at my foot. It was in bed with me, and I was half awake and could not move owing to terror." The patient was much upset by this dream, and lay in bed next morning with the clothes up to his ears. He began a little tirade about his condition, that he was afraid to see anyone, felt a fool, and people thought he was shamming, etc. Of the green snake he said, "It was like a grass snake, with a beautiful green colour. Grass snakes are quite harmless. At my home I used to see them often." The green snake is the infantile part of him, the symbol of that amount of energy that is moving regressively "toward the mother" (cf. associations : "beautiful, harmless, home"). The black snake is the "reality-motif." The dream is comparable with the one cited in Case 1. The two snakes symbolize the two opposing streams of energy in his psyche—one forward and the other regressive. The regressive longing must be sacrificed. The black snake biting his foot is connected with his struggle against masturbation, the foot being (racially) of phallic significance. He was putting up a very poor struggle at the time against self-abuse, being practically at the auto-erotic infantile level.

infantility (i.e., that amount of psychic energy that has gone in the regressive direction and evaded proper application to life).

In both the above cases the goal that is substituted for the normal goal of progress and achievement is a regressive one, and is found in the depths of the individual's own psyche. This goal, however, which forms an incident in the theme of many myths, is impossible as a permanent resting-place, because it satisfies only one-half of man's innate psychic tendencies. The same goal is found in the paradise myth, because it is essentially that state of paradise in which a man, faced by the terrors of war, would fain find himself. But we are told in the Genesis myth that man, when he was expelled from paradise, had to earn his livelihood by the sweat of his brow (forward-striving), and an angel with a flaming sword, that turned all ways, was put before paradise. This myth expresses—as do all myths—a deep psychological truth. The angel with the flaming sword (Freud's incest barrier) cannot be approached without the development of fear and anxiety, and once any regressive movement towards paradise sets in, that “guardian” is inevitably roused. The following dream shows the paradise-motif, which is exactly comparable with the mother-motif.

CASE 3

The officer, aged thirty, had managed to sustain a period of almost a month of severe fighting after battle-dreams had set in—a remarkable achievement. When the collapse finally came it was very profound. A pure anxiety-neurosis developed. He was incapable of doing the simplest things for himself. A violent tremor possessed him. He could not endure bright light, and could scarcely understand ordinary speech. (Speech was almost impossible to him for some weeks owing to a stammer.)

Dream.—“I suddenly was under heavy shell fire, in France, on horseback. I went off as hard as I could, but the shells followed me. I came to a stream. An old man was in

charge of a punt, and I got on to it, leading my horse. Shells were falling close to the bank. The old man took me over to the other side. The horse disappeared, I think, on the journey, although the stream was quite narrow. On the other side of the stream all was quiet and beautiful. There were beautiful flowers and trees, and there were no shells and no more war."

In his unconscious phantasy he escapes from the turmoil of this world into paradise—a thing which is, unfortunately, only possible in phantasy. The disappearance of the horse (the physical energetic component not needed in paradise), and the symbolism of the old man and punt, are interesting points in the dream example.*

I have said enough to indicate the significance of regression in its broadest aspect, from the psycho-analytical standpoint. It is now necessary to examine that form of regression that is so frequently encountered during ordinary treatment of neurotic cases and estimate its significance.

II

Neuroses, whether of civil or war origin, show a peculiar tendency to fluctuate. A patient who has suffered from an anxiety state, with battle-dreams, insomnia, hallucinatory projections, giddiness, confusion of thought and depression, may recover under treatment in hospital. When he is sent out he may relapse straightway into his former state, and then perhaps recover spontaneously a few days later. Or a stammerer may reach a point where he is apparently cured, and then fall back once more into the full tide of his neurosis. During actual treatment these relapses are continually observed, and their significance remains obscure as long as attention is concentrated on symptoms alone.

This peculiarity illustrates a mechanical aspect of *regres-*

* Reductively considered, the old man is the "father" who permits the dreamer access to the forbidden place (wish-fulfilment). Constructively, he is more than this. Cf. the myth of Charon and the lower world and many allied myths.

sion. In this aspect regression is a transient backward movement, gradual or sudden, the result of which is to *revive a former mode of reaction*. Any task that has to be faced, however slight, may set up regression and reanimate an old neurotic system with full intensity. Getting up for the first time, or going out for a walk, or associating with other patients, or being medically boarded, may precipitate regression. A change of environment, a slight accident, the necessity of taking up work, or the prospect of marriage, may cause regression in a patient who was thought to be "cured." The old symptoms reappear, and even the battle-dreams may return. In such cases it is clear that a consideration of these symptoms alone is useless. The relationship of the revival of symptoms to the problem or task that confronts the patient must be considered, and a dynamic psychological view propounded.

A closer study of the process of regression shows that successful adaptation to the small tasks of existence is essential for the deliverance of the patient from his neurosis. When adaptation fails in a recovering neurotic—as in any circumstance of slight difficulty—the neurosis becomes "puffed up" or regressively animated, and the symptoms appear for a time in their old form. An energetic view of neuroses therefore becomes necessary when those facts are considered. What is it that puffs up the deflated system of the old neurosis? Presumably it must be energy of some kind that is dammed back and revivifies an abandoned system. If a stream is suddenly blocked, backwaters far behind the dam become flooded. In view of the fact that the reanimation of a neurosis occurs when some relatively difficult task in adaptation is to be faced, we can realize that, in regression, *energy which should have gone towards the overcoming of the task turns inwards and revives a former mode of reaction*.*

* See Jung, *Analytical Psychology*. Ballière, Tindall & Cox, second edition. Regression links up with repression in this way: looked at from above, the individual, during psychic strain, endeavours to keep down,

Whenever regression occurs the cause must be looked for in existing circumstances. If the physician realizes that a revival of old symptoms must mean a retreat of energy from some task or problem that confronts the patient, he knows that the symptoms themselves are only of secondary importance. The symptoms, then, will not transfix his attention and exclude a wider understanding of their meaning. What is of primary importance is the peculiar personal way in which the patient looks at the obstacle, whatever it is, that has to be overcome, and the overcoming of it.

The situation demands some form of analysis, because, even though the obstacle be obvious (and this is not always the case), the way in which the patient looks on it must depend on inner psychological factors. His special disability in this respect requires consideration. Apart from pre-existing conflicts due to personal development, the question of psychological types cannot be neglected. What is easy to one man is not necessarily easy to another. Looking at the problem of types from the physiological standpoint, it would not be expected that a man with thyroid deficiency would see life in the same way as a man with pituitary deficiency. In this same way, from the psychological standpoint, a man who had always developed his thought life at the expense of his feeling life would not find it so easy to adapt himself to an emotional situation as a man whose feelings were well differentiated, but whose thinking was relatively poor. In estimating the causes of regression in a particular case, therefore, not only must the nature of the task be discovered, but also the inner psychological disabilities which magnify the difficulties of the task so as to make adaptation temporarily impossible.

III

From the neurological—or, more properly, from the psycho-physiological—standpoint the conception of regression or repress, the infantile modes of behaviour that exist dynamically in him, which are becoming increasingly active owing to the regression of psychic energy from the task that confronts him.

sion links up with the central teaching of Hughlings Jackson on dissolution in the nervous system. In diseases affecting the brain, he emphasized the fact that destruction of nervous tissue cannot produce positive symptoms. Whatever positive symptoms appear must be due to the activities of nervous elements that remain intact. The observation, though it may appear obvious on reflection, is still neglected by probably the bulk of neurologists, who still describe the symptoms of nervous diseases in terms of the destructive lesion (negative factor). "I submit that disease only produces negative mental symptoms answering to the dissolution, and that all elaborate positive mental symptoms (illusions, hallucinations, delusions, and extravagant conduct) are the outcome of activity of nervous elements untouched by any pathological process: that they arise during activity on the lower level of evolution remaining." *

In this paragraph of Jackson's is contained the key that will unlock the mystery of mental disturbance. The rise of the activity of modes of consciousness different from those of the normal waking state is not a meaningless, inexplicable phenomenon, but is the expression of sublevel functioning. This "deep" neurology is comparable with the "deep" psychology of modern times. In sleep there is regression from normal levels and obliteration of the discriminative logical mode of thinking which characterizes the waking state. The absence of discriminative functions constitutes the negative factor, but the rise in the dream-level activities constitutes the positive factor, and the mode of consciousness that now manifests itself is to be regarded as a reanimation of an earlier mode of psychic activity. In this way the dream has come to be regarded by Jung and his school as the survival in us of a primitive way of thinking. It is for this reason that the dream links up with mythology, folk-lore and primitive thinking in general. "A dropping away of the last acquisition of the function of reality (or

* *Evolution and Dissolution of the Nervous System*. Croonian Lectures, 1884.

adaptation) must of necessity be replaced by an earlier mode of adaptation.”*

It is in this way that dreams come to have a symbolical meaning. To understand them we must study that mode of representation that is found in myth and folk-lore, where, for example, the phenomena of nature and the moral conflicts of man are represented anthropomorphically and concretely. The same method of representation exists to-day in cartoons, and cartoons are understood by us because we have, surviving in us still, that way of looking at the problems of life which puts abstractions under the guise of pictorial images. The dream is thus, regressively considered, an archaic function—that is, archaic in comparison with our logically directed thinking which is of more recent acquisition. It must not be considered archaic in a derogatory sense.

Jackson postulates various levels of nervous arrangements, progressively more complex in an evolutionary sense, and in speaking of the results of dissolution, of the highest or most evolved cortical level, he says, “There is a defect of consciousness significant of dissolution of the topmost layer along with the *rise of a certain kind of ideation significant of increased activity of the second layer*. The double condition is roughly analogous to ordinary sleep with dreaming.”† In mild cases of head injury, with bruising of the pia-arachnoid and consequent local interference in the nutrition of the cortex, an “unfocussed” mental state, corresponding with that observed in patients with pure anxiety states, is not uncommon. From the organic standpoint, such a patient has a partial dissolution of his first level of nervous arrangements; while in the pure anxiety cases, the patient has undergone some degree of psychical regression, and, in place of an adapted discriminative mental function, he has an excess of emotion and a greatly increased phantasy or dream life.‡

* Jung, *Psychology of the Unconscious*, p. 153.

† *Ibid.* No italics in original.

‡ For a fuller discussion of the subject see “Conception of Regression in Psychological Medicine.”—*Lancet*, June 8th, 1918.

THE ANXIETY FACTOR

CHAPTER VIII

THE MOTHER COMPLEX

BY H. CRICHTON MILLER, M.A., M.D.

Formerly Medical Officer in charge Functional Cases, No. 21 General Hospital, Alexandria. Late Consulting Neurologist, 4th London General Hospital.

INTRODUCTION.

Importance of ætiology in the study of war neuroses—Causative factor in classification—So-called "shell-shock" cases : a limited number of these due to shell-shock concussion. Emotional strain subjective cause in majority.

AN ANALYSIS OF A GROUP OF SHELL-SHOCK CASES.

In this group chief ætiological factor developmental. Cardinal feature being "an inability to adapt to situations requiring independence of thought or action."

(a) *The Psychological Factor in Adaptation.*

1. Abnormal mother dependence induces a failure of character development.
2. "Direction of interest," the normal method by which the interest of the boy travels through a definite rotation of psychological phases.

(b) *Conclusions Inferred from Direction of Interest.*

1. Full and normal maturity only achieved after an average of twelve years of homosexual interest.
2. Elimination of any phase causes hiatus in character development.
3. Failure to develop from first to second stage of interest :
(1) very usual ; (2) very frequently due to father's addiction to alcoholism.

(c) *The Cases of Twenty-eight Patients Reviewed.*

They were rather over 10 per cent. of total number of war neuroses under care at the time—78 per cent. were found to be single men.

(d) Treatment of These Patients.

1. By psycho-analysis. An understanding of the faultiness of his own values.
2. By re-education. A belief in the necessity of detaching his interest in mother or mother-memory lest he fail as husband, father, and bread-winner.

OUR view of the neuroses is generally an objective, and therefore superficial, one. We become confused by the variety of symptoms, and, because we make little attempt to formulate a theory of causation, we are unable to reach an adequate classification. In the present chapter, I propose to take a single group of cases, and link it up with a definite causative factor, in order to indicate for it a logical line of treatment.

The cases in this group are frequently labelled "shell-shock." A certain proportion have undergone true shell-concussion; the majority have broken down, either from the emotional strain associated with trench life, or from the more vague, but yet potent, factors of the chronic apprehension of danger, which all military life tends to induce. But whether the element of "shell-shock" enters into the causation of the case or not, my contention is, that in the group I am describing, and of which I shall presently give examples, the chief ætiological factor is one which has arisen in civil life, one that is not congenital, but developmental, and one that affects not only military efficiency, but the whole range of a man's capacities.

We are all familiar with the lad brought up as "mother's darling," who has acquired an unenviable reputation for timidity, generally coupled with vanity or priggishness; but what is not generally recognized is the extent to which the causative factors which determine this familiar result operate. Their effect is discernible in various types, but leads to one main result. The cardinal feature that we find in such cases is an inability to adapt to situations requiring any independence of thought or action.

Medical psychologists of to-day are familiar with the view that neuroses are the expression of a failure of adaptation

on the part of the individual. This view gives at once a guiding principle in all our researches into the causative factors which lie behind the development of neurotic conditions. With this principle before us we have to ask ourselves in each case why a failure of adaptation occurred.

It is here that the ætiological factors differ in different cases. The patient may quite correctly indicate the environmental problem which he has failed to solve, and which brought about his neurosis, but he will not be able to indicate those inner psychological dispositions that made the solving of the problem impossible. It is for the physician to ascertain the nature of these psychological factors which make certain adaptations in life so difficult.

In this paper I deal with a number of patients in whom the psychological disability is closely concerned with a dependence on the mother—or upon a mother substitute. This dependence, normal during a certain stage of life, becomes pathological as the patient grows up. In the type which I have termed “mother’s darling,” the dependence on the mother and *identification* with her is exaggerated. This exaggeration tends to lead in later life to a definite failure in the development of character.

In order to appreciate the way in which this failure of character development occurs, it will be necessary to consider the normal method by which the emotional interest of the boy travels through a definite rotation of phases. In Freudian terminology this is called “fixation of libido”; I prefer to define it as “direction of interest,” for, though I have no desire to enter upon the controversial side of psycho-analysis, I hold most strongly that such a mechanism as I am here describing has a far wider application than that denoted by the word “libido” or its English equivalent.

The newly-born infant is completely egocentric, but he very soon develops a real interest in his mother, whom he associates with nourishment, care, and protection. Between the ages of six and eight or thereabouts a boy should begin to develop an interest in his father, and this should increase

as his interest in his mother tends to some extent to wane. From six to twelve are the years in which hero-worship is concentrated upon the father. During the school years, say from twelve to eighteen, the interest is mainly fixed upon schoolfellows; it begins as a hero-worship exactly equivalent to that of the father, the father's position being taken by the head of the school, the captain of games, or some other individual who personifies strength, courage, and self-assertion.

But this hero-worshipping attitude gives way as the boy's own position in the school allows him to become self-assertive, and with his self-assertion the elements of patronage and condescension enter into his psychology. Until the middle of the school age, therefore, the direction of interest has been more or less from below upwards, but, as puberty arrives, it tends to take place from above downwards; in other words, the attitude becomes one of complete self-assertion. If the youth has passed through the adolescent period without any deviation from the normal, he will, at about the age of eighteen, direct his interest, and with it his self-assertive tendency, towards the other sex, and he will develop those characteristics of dress and appearance which have their biological antecedents in the plumage of the peacock.

Now, in considering this rotation of phases it will be observed that the first two and a half are negative as regards self-feeling, whereas half of the third is positive and preparatory to the permanent attitude of self-assertion associated, as it necessarily should be, with independence, sense of responsibility, courage, chivalry, and so on. Further, it will be noted that the second and third stages are homosexual, whereas the first and third are heterosexual. From this follows the intensely important truth which so few medical men seem to grasp, that full and normal maturity is only achieved by passing through something like twelve years of boyhood and adolescence, during which emotional interest has been primarily fixed on members of the same

sex and, if anything, turned away from those of the other. Thus it will be seen that homosexuality, as it occurs in boarding-schools, training-camps, and elsewhere, is not some strange and unaccountable transmutation of sex appetite, but a phenomenon easily explained and understood. The boy's life of phantasy and romance throughout these twelve years dwells entirely with the male sex, so that, if the flame of passion bursts out during that time, the material most likely to catch fire is homosexual, and, if the conflagration spreads far enough, the boy's future will be fixed and he will never pass out of the third stage into the fourth. The ordinary pursuits, amusements and occupations that attract the normal young man fail to attract him, in so far as they contain the elements of heterosexual affinity, recognized or unrecognized.

It will be readily understood that the elimination of one or both of the homosexual phases must cause a hiatus in character development. In a certain number of cases the third—that is, the schoolboy phase—is cut out. I recall one of the worst cases I have treated in which the entire psychology of the soldier was dominated by his father. He constantly used such expressions as, "My! he did put the wind up us, did father; but, mind you, he was good to me."

This man, aged twenty-six, had never possessed a latch-key; he lived in his father's house, on his father's bounty, working with immense diligence and perseverance to the value of about £2 or £3 a week, but receiving no wages at all; he had never formed any friendships at school, or shown any concern later for the society of women; in short, his interest had been absolutely fixed at the second stage of development, and the combination of terror and admiration inspired by his father held him there, hypnotized like a rabbit by a boa-constrictor.

Cases of this kind in which the passage from the second to the third stage is blocked are not rare, but they are much less frequent than the group I am about to describe, in

which the transference from the first phase to the second does not take place. In such a case the boy's interest remains fixed at a very early age upon his mother, and when he is somewhere about twenty he tries to transfer it to a sweetheart, frequently only with indifferent success. I venture to express the opinion that very many war neuroses occur in youths who are wrestling with this particular conflict—that is to say, who are struggling to make the adaptation between “mother's boy” and “sweetheart's young man” without having passed through those normal phases of homosexual development which have been described. The reason why cases of this kind are so common is, I believe, largely associated with alcoholism, in that very few boys about the age of five to seven are terrorized by their fathers unless the father be addicted to alcohol. It is impossible for me to believe that there is merely a chance connection between the military neuropath and the inebriate father. Nor am I prepared to allow that the regressive tendency, as shown in the father's will and his alcoholic indulgence, is a sufficient explanation on the lines of heredity of the son's failure to make good. The hereditary element no doubt enters into it, but in my opinion the developmental flaw is far more apparent.

(1) Private J. M., 375752, age twenty, single, complains of headache, vertigo, and weakness of legs. In May 1917 he was blown up, did not lose consciousness, but was deaf and dumb when he reached dressing-station. Deafness lasted a month, but speech has recovered to a certain extent. *The father was a worthless drunkard, the mother died when patient was seven.* He has always been shy, and avoids the company of women at all times.

(2) Private J. D., 102121, age thirty-two, complains of headache, vertigo, and stutter. In July 1917 he was blown up and was unconscious for some hours. In October 1917, when he had returned to the lines, he

collapsed under a heavy bombardment. *The father failed in business, and took to drink when the patient was twelve ; in consequence the mother and family left him ; the patient was, and still is, the support of his mother and sister. He is the only son.*

(3) Sapper J. H. F., 130226, age twenty-three, single, complains of headache, depression, and stammer. In June 1916 he was buried for two hours : he remembered nothing for some days after he was rescued. In April 1917 slight shell-shock without unconsciousness. *The father was always a heavy drinker, and now threatened to leave the mother.* While the patient is under treatment there are frequent relapses, due to receipt of letters from mother complaining of father's cruelty.

(4) Rifleman A. P., 374657, age nineteen, complains of headache, nervousness, vertigo, insomnia, pains in back and legs. In September 1917 was blown up and unconscious for three days. Always intensely sensitive and shy. *Father used to be a very heavy drinker ; patient was always frightened of his father, even when sober.* Three years ago patient endeavoured to intervene when the father attacked the mother. In reply to a question referring to this incident, which was put while the patient was hypnotized, he wrote : "He was very drunk, and he was going to kill me because I took my mother's part." In the conscious state no details could be elicited. *The patient is an only child.*

(5) Corporal J. S., 32402, age twenty-seven, single, complains of headache, nervousness, loss of memory, and tendency to weep without provocation. In November 1917 was blown up and unconscious for twelve hours. In December of the same year, after rejoining his unit, disappeared during a bombardment, and was subsequently found wandering at the base, unable to give an account of himself. *The father was a very heavy drinker. "He used to knock me about something cruel."* In consequence the mother and family left him when patient was fourteen.

They went to a neighbouring town, but lived in constant dread of the father finding them there. *The patient is an only son.*

(6) Private J. P., 2478, age twenty-one, single, complains of loss of sensation in right leg, headaches, and loss of memory. In August 1917 was blown up, not unconscious, mute for one day. Paraplegic for one month. *The father was a heavy drinker, but never violent to patient or mother. The patient is an only son.*

(7) Private W. H., 7099, age twenty-four, single, complains of headache, nervousness, weakness of legs. In September 1917 was blown up and buried, unconscious for a few minutes. *The father was a dipsomaniac, who was in an asylum for a year.* The patient states, with unnecessary warmth, "that he is not interested in girls at all."

(8) Driver J. M., 18366, age thirty-five, single, complains of headache, pains in limbs, burning sensation in feet. In July 1917 the symptoms came on *under heavy fire.* *The father used to "knock mother about," although she was a cripple in a wheel chair.* The patient never had the courage to intervene, but once when he was about twenty "he threw the cream-jug through the window." Recognizing the futility of this protest, he said, "It would have been better if I had gone for him." Since the war he has tried "to court a young lady," with complete failure. *He was an only child.*

(9) Driver H. B. S., 845227, age twenty-three, single, complains of headache, vertigo, lassitude, loss of memory. In April 1917 a shell burst near him, and he was "unconscious" for forty-eight hours. The patient has been, and is, subject to fits of the classical hysterical type. *The father was always cruel to the mother, and she left him when patient was five.* Everything is referred to the mother—e.g., "If I went back to France it would kill mother." "I've got a best girl, but I don't care what she thinks, I prefer my mother," and so on. *The patient is an only child.*

(10) Gunner J. L., 39953, age twenty-two, single, complains of headache, insomnia, weakness, and pain in the eyes. In July 1917 he was blown up and rendered unconscious for several hours. After this he seems to have suffered from many amnesic attacks, in one of which he was put under arrest as a deserter. The father died when the patient was a child, and *the stepfather was unkind. The patient is an only son.* The mother became insane, and is alleged to have died on hearing that the patient had enlisted. He reproaches himself for having caused her death. He states that the sister is everything to him, and that his greatest worry is lest anything befall her. "I am everything to her." When interrogated about his sex life he replies, "I am not much worried by that sort of thing."

(11) Second Air Mechanic E. H., 58240, age twenty, married, one child, complains of dizziness, headache, insomnia. After three months in the trenches patient developed present symptoms. He was never exposed to shell-shock, and his parents are both alive. *His father constantly finds fault with him, and his mother stands up for him.* (As this is one of the few married cases of the series, it is significant that the marriage took place without the knowledge of the parents. It is still more significant that the patient constantly dreams that his father is dead.)

(12) C. E. F., 112294, age twenty-five, single, complains of pains all over the body and weak feet. Has never served overseas. He says, "*My father carried on with another woman while my mother was dying of cancer.*" Mother charged me to have nothing to do with my father after her death. I have always been fond of my own company; I have never bothered about girls."

(13) Private J. M., 260369, age twenty-five, single, complains of headaches and tremors. In November 1917 was blown up and unconscious for about twelve hours. The father drank, and was very strict with the children.

Between the ages of twelve and thirteen the patient was always worried lest the father should attack the mother.

(14) Private W. A., 305372, age nineteen, single, complains of nervousness, insomnia, jerking of head and hands. Had sunstroke in Egypt in August 1916. In September 1917 was blown up and unconscious for several hours. *The father began to drink one year after the patient's birth.* He has steadily gone downhill from being a prosperous professional man. When patient was a child he was constantly thrashed by his father. The father is now serving, and came to visit patient while he was in hospital. He was intoxicated at the time. *Between the ages of eight and seventeen the patient has frequently seen the father knocking the mother about.* (This history was only elicited by the aid of automatic writing.)

(15) Gunner O. M., 109684, age twenty-six, single, complains of nervousness, numbness of spine and head, feelings of non-reality. He stammers very badly, and weeps copiously on the slightest provocation. After being for a few weeks in the trenches he lost control of himself for no apparent reason. He was in hospital for three weeks, at the end of which time he went back to the trenches and became paraplegic one hour after his return. No history of shell-shock. *The father was a very heavy drinker. "He used to carry on at home cruel." The patient is an only child,* and the mother depends on him for support.

(16) Private A. S., 12858, age twenty-four, single, complains of headache, giddiness, bad dreams. He was blown up in September 1917, but was not rendered unconscious. *The father was a heavy drinker, and died of drink five years ago. "I was always afraid of father."* He had heard his mother refer to the father's violence, but had never actually witnessed it. "Mother stuck to him—I wouldn't have done." Patient has been the mother's and sister's main support.

(17) Private W. F., 315162, age eighteen, single, com-

plaints of headache and vertigo. Has never served overseas. After witnessing an air raid lost memory and orientation. *Father was a very heavy drinker.* Patient is very much attached to his mother. He says: "I do not care about girls," but he has frequent sexual dreams.

(18) Gunner G. R., 65203, age twenty-eight, single, complains of being "run down." Gradual onset after nine months at the front. *The father drank heavily, and was frequently violent to the mother.* From early boyhood patient has frequently witnessed these scenes and interfered, always with painful results to himself. *He was an only child.* The father died in 1914, and the mother in 1915, after which the patient enlisted. His sexual life is sufficiently significant to bear mention. From five to twenty years he masturbated constantly. At the age of ten he was successfully seduced by a woman of twenty. From that date he had occasional intercourse with women until he was seventeen, when he stopped it, and for eleven years has been continent. He shows definite signs of early dementia præcox.

(19) Trooper F. G., 1401, age thirty-five, married, two children, complains of deafness, headache, dizziness, and dyspepsia. In July 1917 subjected to severe bombardment, after which symptoms appeared. No history of shell-shock. *The father was a definite alcoholic.* *When patient was about six he saw him attack the mother.* Father died when patient was eight, and mother a year later.

(20) Private H. W., 12332, age twenty-two, single, complains of headache, insomnia, nervousness. Before November 1917 "nerves were getting bad." In that month he was blown up and unconscious for four hours. A few weeks later he was again blown up while in casualty clearing-station by air-bomb, after which he again disappeared for two days. *The father used to drink heavily,* and when patient was about six or seven he always fled from him. He remembers his mother with two black eyes after one of his father's outbursts.

(21) Private J. H., 23/663, age forty-eight, married, six children, complains of tremulousness and pains in limbs. The onset was gradual. No history of shell-shock. *The father drank very heavily* when patient was a boy, constantly attacked mother, and terrorized patient.

(22) Private C. S., 35045, age twenty-three, single, complains of unreasoning dread, weakness, and inability to walk. The patient had been on garrison duty in India, and had never been in the firing-line. *The father was a very heavy drinker*, and in consequence the patient's life was one continual dread. *The father thrashed all the children mercilessly*. He would end up with some phrase like this: "If there was no law I would do you in." This lasted till the patient was fifteen, but his fear of his father continues. He constantly dreams of his father. Previously these dreams were associated with somnambulism, and on one occasion patient jumped out of the bedroom window, breaking his leg. Recently the dreams have taken the form that the father is killing the mother.

(23) Rifleman W. H. T., 376071, age twenty-four, married, one child, complains of giddiness, noises in the head, trembling, lassitude. In September 1916 was blown up and unconscious for two days. *The father was always a heavy drinker, and used to assault the mother*, who died when patient was ten. The patient has been roughly handled on various occasions.

(24) Private J. A. H., 22222, age thirty-four, married, five children. Complains of fits (which appear to be genuine epileptic), weakness, and depression. In October 1917 a bomb fell near his tent and "upset his nerves." *The father was constantly drunk and violent up to the time the patient was eighteen, and used to knock the mother down*. Since the age of eighteen the patient has intervened successfully.

(25) Private J. E. E., 10677, age 40, married, two children, complains of headache, insomnia, nervousness. The condition is an accentuation of his pre-war state, and

came on during leave. The father died when patient was three, and the mother when he was fifteen. *Before her death she told him that the father had been unfaithful to her.* This had made a great impression on the patient.

(26) Private G. M., 156074, age twenty-three, single, complains of "no sleep," depression, headache, restlessness. In July 1916, during a coastal bombardment, a shell fell very close to him. He was "unconscious" for twenty-four hours. Seven months later an air-raid experience caused a relapse from which he shows no signs of recovery. He is a Jew. *The father drinks occasionally, but at all times has a violent temper.* "I am mother's favourite." (At this point the patient weeps copiously.) "Father knocks the kiddies and mother about when he is in a temper." "I don't know whether it is due to drink. *He has hit me over the jaw with a dog-whip, and often struck me with his hand. I have never had the gumption to stand up to him.*"

(27) Rifleman B. I., 22230, age twenty-seven, single, complains of headache, dizziness, nervousness. In August 1916 the patient was blown up, and remembers nothing till he found himself at the base. He has never been boarded, as he always "comes over bad" at the prospect. *Both parents are alcoholic.*

(28) Corporal R. C. M., 10345, age twenty-six, single, complains of headache, tremor, and weakness of eyes. In February 1916 he was blown up and rendered unconscious for three days. In September 1916 again blown up and unconscious for three days. In October 1917 blown up a third time, but not rendered unconscious. The father had been a soldier in India, *and used to take "mad fits."* *Up to the age of sixteen patient used to witness these outbursts, during which the mother used to be assaulted. He intervened sometimes and has been struck.* The mother died when the patient was eighteen. The patient gets on "well enough" with the father now. When asked if he had any worries, he gave the following unusual reply: "I'm afraid they may call up my stepbrother." On further interro-

gation it transpired that this stepbrother, who is older than the patient, gets on very badly with the father. It is therefore presumable that the patient has identified the stepbrother with his mother, and that his affect has been fixed on him by the latent father antagonism.

In reviewing these cases it is to be noted that they constitute rather over 10 per cent. of the cases taken during the period, but as neither my assistants nor myself realized the importance of this factor for some time, many opportunities of closer investigation were certainly missed. It is my opinion that, if carefully examined, at least 20 per cent. of functional cases have an element of parental fixation.

Of the twenty-eight cases, twenty-two, or 78 per cent., are single, though the average age is twenty-six years four months. Many have suffered shell-shock sufficient to account for a long invalidism, but it is only by examining the cases that have not been in the firing-line that one realizes the importance of the causative factor here indicated.

With regard to the treatment of these cases, analytical procedure is, of course, desirable, and the fuller it can be, the more satisfactory will be the result.

The patient must be made to realize that his values are all wrong, that he lacks self-reliance because he always relied on his mother; that he has failed in the will to power because he did not sufficiently admire his father's power; that he has not succeeded in asserting himself because he did not sufficiently assert himself as a school-boy or during his adolescence, and that he will fail as a husband, as a father, and perhaps as a breadwinner, unless he can detach his emotional interest from his mother or her memory.

CHAPTER IX

PSYCHO-ANALYSIS

BY MAURICE NICOLL, M.B., M.R.C.S.

Formerly Medical Officer, Empire Hospital for Officers.

AND

JAMES YOUNG, M.C., M.D., M.S.

Formerly Medical Officer, Military Hospital, Maghull.

INTRODUCTION.

Psycho-analysis, movement in psychological medicine comparable with modern movement in neurology—Dream life, evidence of deep level activities in psyche—Evolutionary view necessary.

GENERAL PRINCIPLES.

Psycho-analysis deals with unconscious tendencies behind neurotic symptoms.

The Unconscious Mind.

Two methods of perception, the conscious and unconscious—Unconscious factor in determining conflicts, inhibitions, compulsions, eccentricities, prejudices, etc.—Aim of psycho-analysis: To make conscious the unconscious factor which energizes neurotic symptoms.

Adjustments Demanded by War.

Soldier called upon to submit himself to full forces of emotions buried in unconscious racial depths of mind. In war, evolutionary movement of modification partly arrested: consequent reinforcement of primitive values aid to adaptation by normal regression, but where old conflicts unadjusted regression tends to reanimate them. Failure to accept war instinctively necessitates manufacturing personal interpretation—All neuroses result of failure in adaptation. Causes vary:

1. When pre-existing conflicts latent, unadapted, failure due to unconscious difficulties.
2. When largely free from internal difficulties, adaptation fails because limit of endurance reached.

TRANSFERENCE.

Transference is sum total of feelings, conscious and unconscious, of patient towards physician—Positive transference, delicate matter, fluctuating easily because it depends on unconscious factors—Personal responsibility of physician—Good transference enables patient to experience relief.

DIFFICULT CASES.

Patients in whom transference difficult—Cases where transference neglected present difficulties.

PSYCHOLOGICAL TYPES.

Two broad classes in which main characteristics are :

1. Functional palsies with central nervous system involved.
2. Anxiety states in which sympathetic system with ductless glands affected.

Accepted biological rule : Least developed function first implicated under conditions of strain—In anxiety state, function of feeling inadequate—In palsy, function of thinking at fault—These undifferentiated functions motivated from the unconscious, inadequately represented in consciousness, determine type of neurosis.

USE OF DREAMS IN ANALYSIS.

The dream is a product of unconscious activity—Matters inadequately dealt with in life, under or over expressed and latent motives seek form of representation in dreams—Unconscious element of conflict revealed in dreams acts as guide to understanding.

Battle-dreams.

Both pure battle and prisoner dreams represent inner psychological situation of dreamer—Inherent capacity for psychic readjustment varies, but shifting of metaphor and depth of conflict show progress, lack of change points to psychio rigidity difficult to treat by analysis.

WHEN IS ANALYSIS ADVISABLE ?

In war neurotics consideration of certain factors must precede analysis : physical factors in head injuries, latent psychotic and criminal tendencies, conditions of fatigue, age of patient, pre-war neurotic histories, apparent deterioration—Analysis demands from patient intelligence and fundamental moral worth—False educational values a hindrance. Understanding of analytical methods will often enable physician to give needed help by less lengthy means.

I. INTRODUCTION

PSYCHO-ANALYSIS is a movement in psychological medicine that is comparable with the modern movement in neurology.

Neurologists are studying "deep" nervous mechanisms, realizing that the common final path—the peripheral motor nerve—is played upon by several influences that progressively ascend in the evolutionary scale. Thus peculiar involuntary movements are no longer looked upon as meaningless, but an expression of the activity of deep and ancient mechanisms.* In the same way medical psychologists now realize that the peculiar symptoms encountered amongst neurotics are not meaningless, but are the expression of "deep" tendencies which can only be understood through the medium of a "deep" psychology.

But whereas neurologists have the objective brain to work with, and can speak in spatial terms of deep mechanisms, existing in the mid-brain, or in the thalamencephalon, the psychologist has the subjective mind to consider, and in place of basal ganglia he must speak of unconscious psychological activities as distinguished from those which are self-conscious. The psychologist, however, is not without a valuable aid in his subjective investigations, because in searching for evidence of "deep level" activities in the psyche, he arrives at once at the portal of the dream life. Following the Zürich teachings, we believe that the dream is evidence, on the psychological side, of the persistence in us of a mode of representation that belongs to the evolutionary past. It can roughly be compared with certain involuntary movements in cerebral diseases which are now recognized as being due to the persistence in us of ancient nervous mechanisms. The principle involved in such a belief is identical with that which recognizes a cyst in the neck as the persistence in us of the gill slits of the fish. The evolutionary view is thus giving *depth*

* For example, the skeletal muscles, *via* the final common path of the lower motor neurones, are influenced by at least four organized systems—motor cortex, cerebellum, vestibular system, and corpus striatum. Each influence has an evolutionary significance and purpose, and one or another may preponderate at a given moment. In the same way a neurotic symptom has many deep influences playing on it, beyond conscious control.

in the consideration of psychological problems, and making it possible to conceive of neurotic disabilities as complex questions relating to the deep dynamics of the human psyche from whence arise neurotic conflict, neurotic compromise, neurotic inhibition, neurotic compulsion, and the dream life itself.

II. GENERAL PRINCIPLES

Psycho-analysis deals with the deep "mechanisms" or motives that lie behind neurotic symptoms. No neurotic can explain the reason of his phobias, obsessions, anxieties, and other symptoms, because the cause of them is not found in consciousness. Consciousness embraces only a very small part of our total psychic life. We have only to consider how much of our memory is unconscious at any given moment, and also how frequently the dream revives old memories which had passed beyond the reach of conscious effort, to realize that the whole aim of evolution has been to thrust consciousness up to the gateways of incoming experience, thus leaving an immense volume of psychic material in the unconscious. It is to the study of this unconscious mind that psycho-analysis directs its attention. The nature of the unconscious is still under dispute, but the fact of the unconscious is beyond dispute. We may be said to look at every object with two minds simultaneously—with two methods of perception—and every object we look at has thus two meanings for us, one conscious and the other unconscious. When the unconscious significance of an object is very strong, that object has a powerful compulsion effect on us. We find ourselves fascinated or repelled or intrigued in some way which we cannot consciously explain, although we often attempt to explain with an unsatisfactory result. For example, a black cat walks into the room, and an occupant of the room promptly faints or has a bad attack of anxiety. He may say that he has no idea why a black cat has this effect on him, and that he knows the cat is a harmless

animal. Looking at the cat through his conscious mind he finds no explanation for his behaviour, but to his unconscious mind the cat is an object of terror.

It is because of this double mind that humanity possesses that much of the suffering of the world arises. If there were only a layer of consciousness with nothing dynamic behind it, our choices and decisions would be simple and absolute and uninfluenced by deeper factors. If we had conflict, all the elements of that conflict would be conscious. But because we have underlying consciousness a vast deep of psychic forces, of unconscious hates and loves and fears, which clothe themselves in the dream life or reveal themselves in the protean symptoms of the neuroses, our conflicts are not simple and absolute. They are continually complicated by the *unconscious factor* which remains intangible and indeterminate until it is brought up into the full light of consciousness.

It is owing to this unconscious factor that neurotics pre-eminently, and other people as well, suffer from inexplicable inhibitions and compulsions in their daily life, for just as the unconscious is the source of the inspirations and good dreams of humanity, so is it also the source of the sufferings and bad dreams of humanity. The eccentricities, gaucheries and prejudices which are so often accepted as normal and inevitable characteristics of human relationships are determined by unconscious factors as much as are neuroses, and there is a tendency abroad nowadays to recognize this. It is the aim of all psycho-analytic treatment to make conscious the unconscious factor that energizes the neurotic symptoms. Every neurotic is, to a greater or lesser extent, gripped by his unconscious, and the more he is gripped the more is his conscious capacity for life impoverished.

From the analytical standpoint, the human mind is regarded as an evolutionary product, both ontogenetic and phylogenetic, containing beneath the surface a mass of powerful forces some of which conflict with the standards

of civilization. These forces, of ancient racial significance, tend to break loose under certain external conditions. War demands a difficult adjustment on the part of the soldier, who has to throw aside certain of the civilized standards, and release at a given moment many previously forbidden impulses. Looked at from the evolutionary standpoint, the soldier is submitted to the effects of a sudden intrapsychic anachronism. He is taken from a modern suburban environment, and is suddenly called upon to retrace the path of human civilization and submit himself to the full force of emotions that lie buried in the unconscious racial depths of the mind. Some men are able to do this with comparative ease; others fail to do it; while a third group find a temporary adjustment possible.

Nevertheless war gives a peculiar sense of freedom, due to the fact that the progress of humanity is a movement of tension, of continual modification, whereby the primitive and undifferentiated is progressively transformed into the more civilized and the more differentiated. In the atmosphere of war this slow evolutionary movement is partly arrested. Humanity pauses in its upward ascent for a moment, and its emotions leave the more complex patterns associated with civilization and flow back into simpler forms. A sense of freedom and relief is the result, and, from the biological standpoint, a valuable reinforcement of the primitive energy values occurs, so that the new adaptation becomes more possible. But in some individuals, the normal movement of regression, with its consequent reanimation of the primary emotions, is not possible. In the normally developed psychic life it is probably always possible, but in the abnormally developed psychic life, where old neurotic conflicts remain unadjusted and tangle the skein of the past, the regression tends only to reanimate the old conflicts.* Thus some people

* Regression, in its psychopathological aspect alone, has been dealt with in Chapter VII.

broke down at the very commencement of war; others, enlisting in the following months, sought to attain those affluxes of energy that come from a successful regression to primitive values and failed, developing neuroses in their place, long before they came in sight of the trenches. From this point of view war neuroses have a definite relationship to pre-existing abnormal psychological factors which prevent the individual from attaining that basic *attitude* that makes a war adaptation possible. Such a person cannot accept war instinctively, and has to manufacture a personal interpretation of it. He may link it up with some other conflict in himself, in that the war assumes a personal symbolic value—i.e., the religious man sees it as a war between God and the Devil. This linkage may be effective enough. As physicians, we must obviously expect to be concerned more with the old pre-war conflicts and unadjustments of such patients as these, than with the direct effects of the fatigues, strains and horrors of the battle-field itself; in treatment we find their neurotic conflicts have only an indirect relationship to the actual problem of war.

On the other hand, we find a large group of war neurotics in whom pre-existing abnormal psychological factors seem to play a negligible part, and whose neuroses have a direct and definite relationship to the actual terrors and exhaustions that war entails. There are patients who have made a war adaptation without obvious difficulty, which has eventually broken down. Some form of neurosis has resulted. From the broadest standpoint *all neuroses are the result of a failure in adaptation on the part of the individual to existing circumstances*, but it will be seen that the causes of the failure vary. In some, with pre-existing neurotic conflicts which remain latent and unadapted in the deeper levels of the psyche, the failure in adaptation is chiefly due to internal and unconscious difficulties. The man is handicapped from the first by his inner disharmonies, which hold up energy, so that he is left with little force

to apply to the overcoming of his present problems, and he fails to find a satisfactory symbolic value in the war. In others, largely free from internal difficulties and fighting instinctively, the adaptation fails because the limit of human endurance is reached. Men broken by war are not peculiar to this age.*

Whenever there is strong evidence of pre-existing neurotic conflict in a case of war neuroses, analytical treatment is indicated.

III. TRANSFERENCE

The application of analytical methods to the alleviation of neurotic suffering amongst soldiers and officers during the war has been directed mainly toward the overcoming of the repression of such experiences. The original teaching of Freud upon the importance of repression in the formation of neurotic disability has there found acceptance, although the motives behind the repression have been given different explanations. The most superficial observer of war neurotics must realize the presence of mental conflict in his patients. The failure of repression, which brings about the neurotic conflict, has been treated by getting the patient to talk about his war experiences, so as to drain off the painful emotions which he has been unsuccessfully attempting to banish from consciousness, and thus bring about some degree of equilibrium between the conscious and the unconscious levels of the mind. The value of talking about one's inner conflicts does not need scientific proof. It is a fact of ordinary human experience. While a great deal of war literature has dealt with this form of treatment, often from a too

* We are purposely ignoring that aspect of the problem that belongs to the difficult question of the change in humanity towards life problems in general. Old values are certainly losing their force, and a new attitude toward many problems is beginning. But as yet no new values have clearly emerged. We only see the chaos of transition. Without clear values, the spread of neurotic trouble is a foregone conclusion, for humanity falls back and gets gripped by the unconscious.

mechanical point of view, little has been said about the most important factor involved in its successful application. The overcoming of a repression is only possible through the emotional attitude of the patient to the physician. This emotional attitude is the key to all successful treatment by psychological methods, and it is technically known as the *transference*. Unless the transference is watched with the greatest care during any form of analysis, a block is soon reached and all progress is held up. Indeed, a relapse (regression) may precipitate the patient into a worse condition than his former one.

Broadly speaking, transference is the sum total of the feelings, conscious and unconscious, that the patient has in relation to his physician. When these feelings are of interest, liking, respect, admiration, hopefulness, friendliness, etc., the transference is positive. When these feelings are of dislike, fear, boredom, hate, anger, vexation, disappointment, etc., the transference is negative. A transference may be mixed—partly composed of positive and partly of negative elements. For example, a patient may feel awe towards the physician. This feeling is not a good positive transference to work through, being very close up to fear and dislike, and eventually an emotional attitude that makes the patient dependent and bound. The physician whose manner is inclined to rouse this transference habitually will never get far with analysis, and thus will fail to understand his patients' inner conflicts and disharmonies. Many physicians, being ignorant of the nature of the transference that they habitually rouse, find a difficulty in understanding that patients have any psychological trouble, always seeing the patient from the angle that the transference affords. In such a case the fault is with the physician and not with the patient, and can only be remedied by analysis, whereby the physician becomes conscious of what he is unconsciously doing.

Positive transference, once exhibited, is a very delicate thing and fluctuates easily. This is because it depends

upon unconscious factors. When it wanes, it is impossible to make progress with the treatment, and a "resistance" is encountered. It may then be found that the patient is unconsciously identifying the physician with somebody against whom he normally feels antagonistic. The unconscious is continually finding analogies, which appear in the dreams, and thus some action or mannerism on the part of the physician may link up in the unconscious memory with a mass of emotions centring round some individual disliked by the patient. Owing to the *unconscious* identification, the patient assumes a negative attitude to the physician—or, in more accurate terms, the patient's unconscious takes up a negative attitude—and consequently the analysis is held up owing to lack of production of material (phantasies, dreams, memories, and associations). In such cases, the physician feels at a loss, and unless he understands what has happened is forced to abandon the case. If the patient is left with the negative transference, he will tend to *project* it on to all physicians for a time. The symptoms, also, become more aggravated owing to regression. The operation of analysis is then a failure, and, like surgical operations in general, the failure is chiefly due to faulty technique. It must be remembered that the technique of analysis is difficult to learn, and the physician must understand his own conflicts before he can help his patients.*

When a good transference has been obtained, the

* *Example.*—In the early stages of the analysis of a severe anxiety-neurosis the patient had the following hallucination: "I saw you (the physician) come into my room last night. You were dressed as a butcher, and had a sharp knife in your hand. You stood looking at me and I was afraid of you." This shows the way he unconsciously conceived of the doctor at that stage of the analysis. All hallucinations are projections of the dream-level of thought (unconscious activity), and are to be handled in the same way as dreams. Positive transference had obviously not yet been obtained, but after the hallucination and its significance were grasped by the patient, a good transference was effected, with immediate relief. Consciously the patient was doing his best at the time, but in the unconscious he was taking an infantile view of the doctor. All analysis aims at

patient at once experiences relief. This is because the physician then forms a favourable object, in reality, through which the patient can get in some degree in confident contact with life. It must be remembered that a patient with a bad anxiety neurosis regards all reality as formidable. He fears everything. His transference to reality is wholly negative. If he manages to make a satisfactory positive transference to the physician, this forms the first step in that ladder of progressive adaptation to life that he has to climb.*

IV. "DIFFICULT CASES"

It is a matter of general experience to encounter a number of war neurotics in whom positive transference is extremely difficult to establish. They are particularly those patients who have been sent from hospital to hospital—often to ten or more—and have never had adequate handling. Their negative attitude to hospital treatment and hospital doctors is very strong, and a great deal of tact may be necessary before a positive transference is obtained. At times, however, good luck or insight may effect a positive transference speedily. These patients have, to some extent, "organized" their symptoms in the sense that they have *adapted themselves to life through the neurosis*. They find life "good enough" as they are, and they may look upon any attempt to cure them as a kind of desecration. Such a patient can look upon an investigation of his symptoms as an act of violence, or

the overcoming of the "infantility" of the patient's attitudes, by making them fully conscious. Anything in the unconscious exerts a force of neurotic compulsion and causes neurotic conflict. When fully translated into the conscious life, it no longer grips the patient with compulsive force.

* The physician now appears in the welcome light of a saviour on to whom the patient can project his burdens. Up to a certain stage a strongly positive transference is essential, but as recovery sets in the transference must be modified. If it is not modified, the patient will be unable to get on without the doctor, and so will tend to relapse when sent out of hospital.

an impertinence, on the part of the physician. He believes that his symptoms are exceptional, and his reactions towards any attempt to cure them are necessarily infantile owing to the regressive movement of his psychic energies, away from life, towards the goal of complete dependence associated with the beginnings of his existence on earth.* It is obvious that in such cases a series of critical blunders has been made, which render effective treatment a task of enormous difficulty. We feel the need of an effective social opinion, as regards neuroses themselves, to take the place of that inner moral force which is found to be lacking during the analysis of such patients, but unfortunately this is not obtainable at our present stage of evolution. Such patients baffle the most painstaking physician. They must be left to themselves to find their way back to life in their own way. It is certain that many bad cases of this kind will eventually recover sufficiently to make a partial adaptation to normal existence. Even a little intelligent handling may work as a leaven, but to waste too much time over recalcitrant cases is not practicable, because psychological treatment is an extremely difficult, tedious, exhausting task, in comparison with which the practice of organic medicine is child's play, and only a few cases can be undertaken by one physician at a time. It is best to select patients with an eye to their general "make-up," for if the patient has good stuff in him originally, it will be easier to help him to find the "way out" from his neurotic conflict. Of course with ill-developed types it is obvious that any method that works through the mind and seeks to give insight will not be feasible. Neurotics are just like any other big group of sick folk. Some are difficult or impossible to help. Others can be helped a great deal. This fact is not properly understood by critics of modern medical psychology, who often suppose that *all* neurotics should be benefited by a particular psychological treatment, or else

* See Chapter on "Regression."

the psychological treatment is useless. If these critics would think in the same terms of neurological cases or heart cases a more reasonable attitude would arise. For if we were to estimate the value of neurological methods of "cure" in tabes or paresis by the failures, our condemnation of neurology would be severe. We do not condemn brain surgery, although it does not by any means always help the patient. We feel we are doing what is possible, even though it is dangerous, and we hope to learn by each experience. Analysis is a mental surgery, fraught with extreme difficulties, and should be judged in exactly the same light. It is sufficiently clear that our only hope of understanding the deep factors behind neurotic conflict and neurotic symptoms is by way of some form of analysis. Our personal experience of analytical methods is that, properly used, they always give relief, and lay the permanent foundations of a new attitude which will make life a possible proposition to the patient. For the neurotic is sick in his soul, and a gradual reconstruction of his feelings and thoughts is the only way whereby he can be honestly cured. But unless the physician is willing to devote an extraordinary degree of patience and thought to each case, he had better concern himself with the simpler rôle of prescribing drugs and changes of climate and radium baths—all of which may effect a temporary amelioration.

Apart from cases which are difficult owing to natural causes or to past mishandling, there are some cases that speedily become difficult owing to a neglect of the transference. It is, for example, useless simply to tell a war neurotic "to read the papers and think about the war and talk about his experiences to other men." To do this effectively, the patient must work through a good transference, and it is the physician's task to obtain a good transference. Through this medium the "overcoming of the repression" is rendered easy, and the patient may get "a lot off his mind." But the physician must

be prepared to listen at some length, especially if he is not skilled in his subject, for then he will not be able to estimate what is of value and what is not of value. The "repression" always centres round one or more special emotional experiences, and behind them deeper values always lie which have a peculiar meaning for the individual.

V. PSYCHOLOGICAL TYPES

In war neurotics we find two broad classes of cases :

(1) Those in whom functional palsies are the main characteristic.

(2) Those in whom anxiety is the main characteristic. This is a very striking fact, and one that deserves the closest attention. In the neuroses of peace we find the same broad division. On one side we have mainly the central nervous system involved, and on the other side the sympathetic system with the ductless glands. Now, we may take it as a general biological rule that the least-developed function is first implicated under conditions of strain. No one doubts that the neuroses of war are produced by strain of some kind. They are expressions of failures in adaptation. In place of achievement by successful adaptation we have a series of symptoms. If one man's symptoms consist of palsies and another man's symptoms consist of anxieties, and if these symptoms are in both cases expressions of failures in adaptation of the least-developed functions, then it would seem that the least-developed functions in the two cases were not identical. What breaks down in one man manifests itself as a palsy, and what breaks down in another man manifests itself as an anxiety state.

Now, the visceral and endocrine system are most closely linked up with the emotional life. Therefore in the man who develops an anxiety state under strain the least-developed function—that is, the one that would break down first—must be connected with his feelings. His feelings towards the situation to which he has to adapt

himself are not adequately developed up to the point of carrying him successfully through the difficult period. From the logical point of view he may see the necessity of making an effort. His thoughts may be adequate, but his feelings are inadequate.

In the case of the man who develops a palsy the emotional life is not so obviously implicated. The undeveloped function which breaks down does not seem to be connected with his feelings, but with something else. It is therefore possible that his thinking is the undeveloped function that is at fault. How can we regard a functional monoplegia as a primitive expression of a thought? Gesture is primitive speech. A monoplegia is a gesture towards life, negative in character. Functional palsies and anæsthesias correspond in their distribution with thoughts about the body. It is not the arm as an anatomically or neurologically conceived structure that is involved, but it is the *thought* of the arm. The areas of anæsthesia in functional troubles often have extraordinarily non-neurological distributions, which can only correspond with a man's ideas about his body. Our first most primitive conceptions are probably about our bodies.

Now, a function that is relatively undifferentiated exists more beneath the level of consciousness—that is, in the unconscious—than a function that is well developed. Whatever exists in the unconscious is capable of producing neurosis, because it is axiomatic that the neurosis is motivated from the unconscious. A man cannot manufacture a neurosis by conscious thinking, any more than he can add a cubit to his stature. With these considerations in view we should expect to find that the undifferentiated function, lying largely in the unconscious, and only inadequately represented in consciousness, determines the type of neuroses. The man whose feelings lie too much in the unconscious in an undifferentiated form would therefore develop an anxiety state under stress, while the man whose thinking, regarded as a function,

remains largely at an unconscious level, would develop a palsy. Jung regards neurotic breakdown as being due to the struggle between the differentiated function in consciousness with the undifferentiated function in the unconscious, and so far he has distinguished two main psychological types. In one, the extrovert type, the feelings are relatively well differentiated in comparison with the thinking; in the other, thought forms the more differentiated function. Jung has emphasized the importance of the recognition of psychological types in practical treatment by analytical methods, and has pointed out that many failures are due to the lack of understanding of this fundamental question.* So far as we know, no attempt has been made during the war to view neuroses from the point of view of basic psychological types, and it is for this reason that we have endeavoured to give an outline of this difficult problem.

VI. THE USE OF DREAMS IN ANALYSIS

The dream is a product of unconscious activity. It is the chief link that remains between the conscious and the unconscious mind. It is the expression of the unrealized portion of the psyche. Whatever is inadequately dealt with in our daily life, whatever is insufficiently expressed or over-expressed, whatever latent motive lies behind our behaviour, all tend to find some form of representation in the dream. As we have already stated, the neurotic is ill because he is the victim of neurotic conflict, which depends upon a disharmony between conscious and unconscious levels. It is the unconscious element of the conflict which reveals itself in dreams. For example, a man may be sexually impotent, without any organic cause; and consciously he may earnestly desire to be

* The extrovert and introvert types do not exhaust the possibility of further types. Intermediate forms of neurosis are met with, and in these patients the adaptation to life may be made through the main development of a function other than that of thought and feeling. Further work in this direction is looked for from the Zürich school.

normal. Where does the cause of the trouble lie? Obviously it must lie in the patient's unconscious. He is the victim of a neurotic inhibition for which on conscious levels he can find no explanation. In such cases we do not find help in an ordinary conversation, and if we leave the matter at that stage the problem remains insoluble. *Our guidance is not found by ascertaining how the patient consciously thinks of his problem, but how the patient unconsciously thinks of his problem—that is, how he dreams about it.* The abnormal deflection of interest in the unconscious levels, which renders its conscious application possible, will be revealed in this way.

The unconscious has no sense of time that is in any way comparable with conscious standards of time. Consciously the war is over, but unconsciously, for thousands of neurotics, the war is not over. In their dreams they find themselves back in the trenches, or they hear the drone of aeroplanes and see the flashes of bombs. Unconsciously the war continues. In such cases it is not surprising to find that there is an inadequate amount of energy at conscious disposal for the daily tasks of life. If we ask ourselves where the missing energy is, we have only to look at the dream life, and that at once gives us the clue. Whatever we fail to master in life drops into the unconscious; and what we fail to master in life depends on the individual factor—upon our moral make-up, upon our inherent capacity for adaptation. Whatever drops into the unconscious swells the volume of the unconscious content. This means that there is less disposable energy at conscious levels; in other words, the neurotic breakdown becomes imminent. If we break down in face of battle, all that energy that was going out towards overcoming the situation drops into the unconscious and the battle-dreams begin.* Battle-dreams are thus always the sign of

* Various other phenomena of acute pathological regression begin to manifest themselves at the same time, such as "jumpiness," bad memory, lack of concentration, palpitation, anxiety nausea, sweating, and sleep starts.

an adaptation which has failed or is failing. The problem has shifted or is shifting its focus from without inwards. The man has turned away from reality only to be gripped by the unconscious. What was formerly in front of him is now behind him.

Battle-dreams usually begin as repetitions, during sleep, of actual scenes witnessed by the dreamer. They are often more dramatic, and may have an element of grotesqueness in them. The horror may be intensified, and the feeling of helplessness is always pronounced at first. Two main motives can be distinguished in the early stages :

(1) The dreamer is overwhelmed by the incidents in the dream scene. He is usually hopelessly overwhelmed by shells or bombs, and awakes in terror.

Example.—The patient, a gunner officer, had a severe anxiety-state. He was incapable of making any mental effort, was terrified of strangers, and had developed a bad stammer. For the first few weeks he had the following typical battle-dream :

“The scene is a big stretch of snow-covered open country between the Bapaume-Arras road and the village of Mory. The sky behind Mory is always black with storm clouds in the direction of the Hun line. The battery is in action. There has always been another officer present in these dreams, but I cannot recall his face. Perhaps it is D. We were once caught together in a barrage in the snow beside Hebuterne in January. I don't know. Shells begin to arrive, and soon we have to run for our lives with shells all round us. I always awaken at this point.”

(2) The dreamer is taken prisoner. The significance of this, of course, depends upon the patient's attitude towards being taken prisoner.

Example.—A young officer, with considerable musical ability, developed an anxiety-state. His dreams invariably dealt with the theme of being taken prisoner. “I

am in a trench, and the Germans suddenly surround me. I feel terrified and wonder if they are going to kill me. Then I seem to be a German myself, then I seem to remind myself that I am British."

The unconscious conflict here is apparent. In the majority of cases of prisoner-dreams the motive does not approach conscious levels so closely, nor does it in our opinion necessarily signify an unconscious wish fulfilment. We believe that it represents the psychological situation, portraying in the customary pictorial metaphor of dream language the gradual gripping of the patient's energy by the unconscious. One of us had the opportunity to observe the following case, in which the dream points very clearly to an analogy formation round the psychological situation of the patient. An officer with a right frontal injury, who was apparently doing well, began to have a series of dreams which gradually grew more intense. He would find himself in a trench with only a few men at his disposal. A night attack was expected, and he would feel much anxiety about the proper disposal of his men. He would wake at this point. The dream gradually extended itself to include the night attack, and finally he would find himself taken prisoner. His anxiety at this stage was very pronounced, and he would cry out and struggle. Signs now pointed to intracranial tension, and an abscess was suspected. Patient during the day was drowsy and incapable of directing his attention properly to anything. An operation was performed, and a collection of pus was found between the dura and the skull. In this case the dream depicts his increasing disability in indirect language. He had had prisoner-dreams shortly after being wounded, but had been free from them for a period of four months.

We believe that both the pure battle-dream and the prisoner-dream represent the inner psychological situation of the dreamer. His enemy is no longer without, but within; it is no longer the Germans, but the patient's

unconscious that is increasingly gripping his psychic energies. We have only to look at a patient who suffers from vivid battle-dreams to realize how helplessly gripped he is.

As time goes on the battle-dreams tend to change. Scenes of home or incidents of the day may be woven into them. It is interesting to observe that these changes always occur in the opening phases of the dream, which eventually terminates in a battle scene.

Example.—An officer, with an anxiety-neurosis, suffered from nightly battle-dreams concerning his battery at Ypres. Two months later he was still dreaming the same dream, but certain changes had begun, of which the following is an illustration :

“Nurse brings medicine in glass. I put it to my lips. There is a brilliant flash and an explosion. I know a gas shell has exploded in my face, but I am still alive. After the explosion I find myself back at the battery at Ypres in a bombardment.”

The significance of this change must be briefly considered. The whole scenery of the dream may alter in process of time, and yet the theme remain much the same. The dreamer, for example, may find himself battling in the sea, trying in vain to get to a distant lighthouse. In such cases there is not assimilation and resolution of the conflict, but a change of metaphor. Psychic values continually change. The tensions, as it were, remain the same, but clothe themselves in new forms. The problem continually shifts its perspective and yet remains unresolved, but in this continual shifting we must see an attempt at healing, an attempt at finding a way out. The dreams may become greatly elaborated and bear a direct relationship to the changing environment of daily life. In some cases the battle-dreams themselves become weaker and weaker and finally cease. An adjustment appears to have taken place, which may be permanent, although any difficult problem may cause regression and

reanimation of the old dreams. The inherent capacity for psychic readjustment varies in different people, and we believe that the gradual inclusion of new environmental and less warlike features in the battle-dream is a good sign, and that the persistence of the problem in pure battle terms points to a psychological rigidity that makes treatment by analysis difficult.

VII. WHEN IS ANALYSIS ADVISABLE ?

In war neurotics certain factors of fundamental importance must be considered before analytical treatment is thought of:

(1) *Head Injury*.—There are many slight cases of head injury, with persisting symptoms closely resembling neurotic manifestations and often linked with them, in which injury to the dura or pia-arachnoid may be present.

(2) *Incipient Psychoses*.—The strain of war may unmask a latent psychotic tendency. In our experience in connection with anxiety cases the possibility of manic-depressive insanity must not be overlooked. The manic type may find a successful adaptation during actual warfare, but on being returned to a peace environment adaptation becomes difficult. It must be remembered that war calls out the latent criminal tendencies, and these may be only unsuccessfully repressed or eliminated when the war ceases. We have observed a few cases in which there was an enormous criminality expressed in dreams, accompanied by pronounced anxiety symptoms and suicidal thoughts. *Suspicion* is an important factor in diagnosis. The patient may feel when he goes out in the street that people are looking at him and talking of him, etc. This is to be distinguished from the mere timidity or excessive nervousness in the presence of strangers which is common to most ordinary non-psychotic anxiety-cases. *Hallucinations* are not uncommon during the acute stages, and are usually projections of battle incidents.

It is possible that hallucinations of non-battle content are suggestive of a psychotic tendency.

(3) *Fatigue*.—Where fatigue is manifest analysis should not be undertaken. With ordinary rest and feeding many mild cases recover sufficiently.

(4) *Age of the Patient*.—Elderly patients are not good subjects for analysis.

(5) *The General Make-up of the Patient*.—Analysis demands a certain amount of intelligence on the part of the patient, and, what is of even greater importance, fundamental moral worth. Analysis can only work through these factors. We can lead the horse to the water, but we cannot make it drink. It is not necessary that educational values should be highly developed. It is rather a question of native intelligence and native moral worth, and these qualities are met with equally in men and officers. False educational values may be a great hindrance. There is no one so difficult to deal with as the man who thinks he knows everything or the man who is hopelessly bound by some dogmatic religion. Such men are incapable of making the psychic transvaluations necessary for cure.

(6) *Pre-war Neurotic History*.—A clear history of neurotic breakdown before the war will naturally complicate matters. Special attention should be paid to the patient's childhood and boyhood, to his fears, his shyness, impulsiveness, his relation to his parents, etc. Ticks, stammering, bed-wetting, epileptiform attacks, abnormal sensitiveness to particular aspects of life, etc., are important. If there is a well-marked pre-war neurotic history, and the symptoms induced by the war persist, analysis will probably be necessary.

When symptoms have persisted for many months, and cure by other methods seems unlikely, the question of analytical treatment should always be considered. Full analytical treatment is lengthy, and must be regarded in the light of a major surgical operation. Cases should

be carefully selected, and due regard paid to the factors enumerated above. The analyst is rash who seeks to analyse everyone. As long as there is a war environment, the difficulties of getting the patient back to life so that he can make a fresh adaptation to the war are sufficiently obvious. We doubt very much whether bad anxiety cases can ever be made to face war again within a reasonable period. They can certainly be freed sufficiently to face ordinary life as useful citizens.

Anyone who understands analytical methods, and through them has gained insight into the nature of neurotic trouble, can help war neurotics without actually submitting them to analytical treatment.* The majority of war neurotics have no idea what has happened to them. They find their limbs paralysed, or they find themselves gripped by anxieties over which they have no control and subjected to terrible nightmares. Many think they are becoming insane. Any form of treatment, therefore, that gives them some adequate explanation—one carefully adapted to their intelligence—will be of use to them. A good transference and a suitable explanation will effect great relief in many cases, and some explanation of the existence of the unconscious mind helps to give the patient a correct perspective, and prevent thoughts of “evil geniuses” or “devils” or insanity. The mere relation of the nightmare is helpful, and a hint here and there as to their significance may assist.

* The use of ether may be tried, for it would appear that prolonged anæsthesia sometimes “turns the tide,” and the patient begins to recover slowly. Ether takes him to a very deep level of unconsciousness, and it must be remembered that an anxiety case rarely gets into a properly unconscious state, even in sleep. Through the ether, he is taken right down to a contentless level, and this may permit of some necessary readjustment of forces that was otherwise impossible. We have had personal experience of only two cases. In one—a mild anxiety state following a train accident in France—marked improvement followed. In the other a temporary improvement was noticed. It is conceivable that if ether was used in the initial stages of war neurosis, followed by rest, good results might be obtained.

Deterioration is evident in many cases who may or may not show the epileptic temperament. These patients may show impulsive action of an irresponsible nature. They may write cheques for amounts they do not possess, etc. We have had no experience of analysis in such cases, and we doubt very much whether it would be of value, seeing that the fundamental moral worth of such patients is debatable.

Many medical men, not understanding the nature of neurotic trouble, supposed that on the cessation of war the majority of war neurotics would recover rapidly. This view is based on the idea that a neurosis is a manifestation of *conscious malingering*, and it has contributed to keeping up the reactionary attitude towards psychological medicine that is evident in this country. When the war ceased, war neuroses did not by any means cease. A war neurotic cannot adapt himself to civilian life spontaneously. In six severe anxiety cases and two conversion cases (palsies) we observed no change whatsoever. During the weeks following the armistice we observed a case of anxiety-neurosis slowly developing in a patient suffering from organic paralysis, due to spinal injury. In another case, an anxiety state set in some months after the patient was demobilized, while he was attempting to adapt himself to civilian life. It is obvious that civilian life at the present moment presents many difficult problems to anyone returning from the trenches, and we must expect a further outbreak of neurotic trouble. Few men can live by the senses alone, and when the significance of life is obscured and ideals are changing, creative work, through which humanity escapes from the grip of the unconscious, becomes increasingly difficult. It is not difficult to see that humanity is in search of new values at its present critical phase of evolution, and until it finds them neurotic trouble is not likely to diminish.

THE MANAGEMENT OF THE NEUROTIC

CHAPTER X

THE MANAGEMENT OF THE NEUROTIC— INSTITUTIONAL

BY W. H. BRYCE, M.B., C.M.

*Medical Superintendent, Kenlaw House. Late Major (Temp.) R.A.M.C.
Late Officer Commanding, Craiglockhart War Hospital.*

INTRODUCTION.

This account confines itself to war hospitals, and has under consideration : (1) Cases sent from overseas ; (2) cases which failed to adapt to home service. A general feature : " The symptoms had acquired a certain degree of fixity."

THE NEURASTHENIC HOSPITAL.

The Necessary Characteristics and Their Application.

The importance of adaptation of management and treatment to the ætiology of neuroses.

(a) *Personal Relationship.*

Intensive personal relationship between patient and physician guiding principle of cure. Individual treatment the primary basis of therapy—This will necessitate : (1) strict limitation of number of patients per physician ; (2) staffing by whole-time physicians ; (3) co-ordination and organization of the work by head physician.

(b) *Re-educational Methods.*

The Aim.—(1) The after-treatment of certain paralyses and allied conditions. (2) To make the patient an efficient member of society by the help of social, occupational, and other activities—The method must be individual. It must inspire and therefore guide, not control.

1. *Occupation.*—A valuable adjunct to re-education, but not an end in itself. It should be varied, inspire interest, initiative, a sense of usefulness, and so avoid purposeless loafing—The use of farms, hobbies, and the joiner's shop.
2. *Recreation.*—The organization should be unobtrusive. Outdoor sports in re-education against psychical fatigue—Confidence, memory training, and other aids to character, may be taught by various forms of recreation.

3. *Social Life*.—It should foster (1) normal associations; (2) a community sense. It should provide (1) scope for individual development; (2) opportunity for quiet.

4. *Physical Care*.—The importance of establishing physical fitness. The benefit of increasing physical effort after elimination of psychic factors.

(c) *Special Features of Hospital Economy*.

1. Formal classification of patients unnecessary.

2. Advantages of country site and special building.

3. The selection of nurses a difficulty.

4. Discipline should be: (1) strict in essentials; (2) avoid details; (3) capable of exceptions.

5. Provision for acute cases possible.

THIS short account of the management of war neuroses deals with the type of hospitals which existed during the war, in which were received only those cases which had been sent home for treatment from overseas, or which had failed to adapt themselves to home service. The treatment of acute cases in the field is not considered, and is regarded as outside the scope of this paper. The patients mainly catered for were those whom immediate treatment overseas had failed to relieve, and in whom, therefore, the symptoms had acquired a certain degree of fixity. A considerable number had had more than one experience of the front, and many had been under treatment for some time before coming to a special hospital.

In arranging for the treatment of war neuroses in an institution of this type, as indeed in one devoted to any class of functional nervous disorder, it has to be remembered that there are many points that differentiate them entirely from other illnesses. Just as their ætiology is different from that of other diseases, so does their general management and treatment differ from almost all other practice. It is necessary, therefore, that these peculiar circumstances be ever kept in mind in the management of a neurasthenic hospital.

The necessity for a specialized treatment, and, therefore, for special hospitals, was not at first recognized, and at the beginning of the war the neurasthenic hospital did

not exist ; indeed, these were established more or less experimentally, and, their usefulness being apparent, the number was extended to meet the demand. The mechanism for the care of the neuroses, as distinguished from other cases, was completed by the establishment of special clearing hospitals for their distribution to special institutions, and we can truly say that, so far as this country is concerned, the war has been responsible for the development of the neurasthenic hospital to its present stage. The main departures from ordinary hospital practice may, for brevity, be placed under three heads :

- (1) The more intimate personal relationship between patient and medical officer makes special demands on the personnel, and indeed on the structure of the hospital.
- (2) Various re-educative schemes must be provided, and machinery for their execution established.
- (3) Special features in the internal economy of the institution are necessary for the development of social life in the hospital.

In the first place it must be recognized that there can be no mass treatment in any form in the early stage, and that all treatment should be severely individual between the patient and his medical officer.* Indeed, in the majority of cases it must remain so throughout. Ward work is practically limited to the treatment of intercurrent illness, and certain cases where confinement to bed is necessary as a temporary measure. This being the primary basis of therapy, arrangements must be made for separate consulting-rooms for each medical officer, so that every patient can be seen and interviewed separately. The special neurasthenic hospital must, therefore, if it is to be efficient, have a higher proportion of medical officers to beds than the ordinary hospital. One medical officer should not be asked to handle more than fifty cases at

* An exception may be made as described in Chapter V.

the most, and it is only because a considerable number of these will be on occupational and outside re-educative work that even this number can be undertaken. The personal relationship between medical officer and patient is the guiding principle throughout the whole organization of the hospital; everything else is of secondary importance, and should be subservient to it. The ordinary hospital organization of visiting medical staff and house physicians has no place in the neurasthenic hospital, and staffing by whole-time medical officers is the only satisfactory method. It follows that the head of the hospital should be an expert in the treatment adopted, in order to co-ordinate the work and arrange for the establishment of the various re-educative schemes.

With regard to re-educational methods, these naturally run along two paths. In the first instance are included the special re-educative exercises necessary for the later treatment of certain paralyses and allied conditions. The second includes the general re-education in social, occupational, or other activities required to make the patient once more an efficient member of society. The first demand will be met largely by the provision of a gymnasium with the various appliances for re-education in muscular movement and co-ordination, and a skilled instructor should be employed who may also undertake the graduated training against fatigue in its earlier stages. These physical cases will, when sufficiently well, pass like others to re-educative occupation. The second, the training of the neurasthenic to lead an efficient existence again, requires a wide range of re-educative measures. It seems futile to attempt to differentiate spheres of re-education into moral, social, and occupational, for all efficient re-education, whether in self-control, social relations, or technical processes, tends towards the same end. All methods converge and overlap in order to make the patient efficient again, and to enable him to cope with himself and his environment. The finer points in moral re-education

are matters for the individual medical officer, and the special line to follow should be dictated by him.

The arrangement for treatment, as indicated, has its basis in the establishment of a personal relationship between the patient and the physician through which the psychic causes of failure are elucidated. During the early period any attempt at special re-education is of little avail. In the majority of war cases this stage need be but short, in some cases very short, but in others, especially those of long standing, it may be some time before the medical officer is able to judge of the repressions or other psychic disabilities under which the patient suffers.*

Work, games, hobbies, or other recreations, play an important part in re-education, and the successful prosecution of these occupations is a proof of the efficiency of the new mental adjustment.

The neurasthenic so often lacks initiative and desire "to do" in the first instance, and desire and capacity to "carry on" later, that the medical officer must be prepared to show a practical interest in these various activities, amounting to participation if need be. This is often a severe tax, but the want of it spells failure, especially in the earlier stages of readaptation. By such means interest is aroused, initiative is encouraged, and ultimately responsibility is accepted. Professor Chiene had in his dressers' room two pictures indicating the two types of student—a nestful of young birds being fed by the parent bird, and a newly-hatched chick energetically picking about for himself. In re-education the chick is surely the ideal

* It is interesting to know that in Italy the necessity for psychical treatment even in the gross physical disabilities is regarded as a necessity before re-education of the physically disabled man is undertaken. In the abstract of a paper by Prof. Ettore Levi, of Florence (*Lancet*, July 13th, 1918), it is stated that "Re-education as a general measure is doomed to failure if it is not preceded by adequate moral and physical preparation . . . from the initial stage of incapacity. Ideally, this pre-re-education—that is to say, the moral preparation of the patient—should be initiated . . . when he first realizes that he will remain hampered for life by his physical disabilities."

to be aimed at, and improvement can be gauged by the gradual assumption of a less dependent attitude. In the hospital or institution, therefore, the less outside aid sought the better, and re-educative methods should be run with only sufficient advice, expert if need be, to ensure efficient results. Whether the neuroses be looked upon as expressions of a purely regressive tendency, as simply an evidence of failure of adaptation, or as a conflict compromise between instinctive processes, re-educative methods are an equally fitting form of therapy.

In the earlier days many physicians regarded occupation, mainly in the form of definite work, as *the* method of treatment *per se* without any special form of psychotherapy, and they would have organized the hospital on an occupational basis alone. This I am convinced is wrong: pure "ergotherapy" is applicable only to a small group of cases of simple inertia, apart from certain high-grade defectives, who should never have been enlisted, and for whom work is a primary educational process. Occupation as an adjunct is another matter, and in re-education it plays a big part. The danger of a well-organized "work" side to a hospital is that reliance is apt to be placed upon this alone, and, in the desire to keep the work running, unsuitable cases, or cases in unsuitable stages, tend to be given premature occupation. This cannot be taken as an argument against the provision of a technical side; it is simply a question of care in selection. In a hospital for men work will naturally begin with light duties in ward and kitchen. The next step will depend on local possibilities—for example, at Maghull the men next passed to the farm where work could be graded in any way desired. Different hospitals will have different varieties of work depending on their situation, but the ideal would be to have a sufficient variety to enable men to find congenial and suitable outlets for their energy in appropriate modes of re-education back to a natural environment. It is obviously impossible to provide every man with his

own civil employment, nor is this in any way necessary. The main thing is to provoke the patient's interest, for work without this will be a drudgery and will lack the greater part of its re-educative value. Mere purposeless occupation which evokes no interest is of little profit, and indeed is likely to be even harmful. In the simplest form of work a definite result must therefore be aimed at. As a single scheme, farm work, especially if varied stock is kept, will carry us farther than any other, but to many it will not appeal. Workshops should be available, and it will generally be found that carpentry fills the largest gap. The neurasthenic is specially apt to think that he can never again be the man he was before, and useful work offers the best chances of convincing him of his error.

In an officers' hospital hobbies will largely occupy the same place in the re-educative scheme as work does with the men. The nature of the hobby is of little importance, its value being the intelligent occupation given and the interest aroused. A great deal can be done in the establishment and direction of suitable occupations of this sort, and the more patients occupied in the same pursuit the better the result. Photography illustrates well how, and how not, to organize a hobby; mere taking of snapshots leads nowhere, but developing, printing and toning in the different processes are quite another matter.

Much solid work can also be done in a well-equipped officers' hospital on the land or in the carpenter's shop.* Apart from the positive re-educative aspect of occupation in the hospital, the negative aspect of the prevention of purposeless loafing makes something of the sort necessary. This has been recognized in other spheres of medicine, for

* Amongst the most successful and productive forms of occupation are those which combine what may be called work and play. At Craiglockhart we had a model-yacht club. Each member had to make his own boat from a block of wood, cut the sails, rig her, and then sail her. Many other occupations can be devised on similar lines.

the after-results, mental or physical, of prolonged purposeless inactivity can only be bad.

Recreations should be made to play their part, but unobtrusively, being treated frankly as play. It is needless to point out the value of out-door sports of all kinds from the moral and physical re-educative standpoint, and, whenever possible, arrangements should be made for their adequate inclusion. In an officers' hospital, where the physical work question is difficult to arrange, sports will bulk more largely than in a hospital for men, but every effort should be made to provide and foster seasonal games here also. In the re-education against psychical fatigue nothing is so good as out-door games, because of the distraction produced by the interest in the game. Give a few lads a football, if only to kick about, and they will soon forget their fatigue; just as a golfer, if given half-a-dozen balls to practise approaching, will soon be out with his whole kit, if suitably encouraged. Billiards can always be obtained, and the game is valuable if only for the confidence gained by performing before others; while card games, especially with a whist basis, provide an excellent means, not only of diversion, but also of memory training. Music of all kinds there will be, as in other hospitals, but the constant round of provided entertainments is of little value compared with the concert or variety entertainment given by hospital talent, which many besides the actual performers have assisted to produce.

In a neurasthenic hospital the great majority of patients are up and about all day. The social life between them is therefore fostered from the first, and existence in hospital is made as normal as possible. The officers' hospital should be run socially on the lines of a country house, or, more correctly speaking, on the lines on which a country club might be organized, the directing of the different activities giving occupation to a considerable number. Full scope, however, should be given for individual development and

personal tastes. In a hospital for men, apart from the fact that they sleep in wards, there should be little to indicate hospital régime beyond the few regulations necessary to ensure order. The morning is filled by the occupations prescribed, in hospital duties or in physical re-education. The recreation time is spent as desired, either in or out of hospital, but out-door sports should be strongly fostered. Billiards, music, or dancing complete the social side of the hospital, nor should the library be forgotten. If possible, a room should be provided where the patient can read or write without disturbance. This socializing of the hospital is of the first importance, although it requires much discrimination in execution. Social pleasures and sociability are by no means all that should be striven after, as these may be, for the individual, entirely selfish. Effort for the common good, and the subordination of self in the interests of the hospital or ward, are the real end, and constitute the surest way to the revaluation of self, than which nothing is more urgently needed by the average neurasthenic.

The residence in hospital should not be unduly prolonged after adaptation is judged to be satisfactory, remembering that the adjustments have not simply to be made, but have to be stabilized by exercise in the direction apt to upset them. The socializing of the hospital and the re-educative occupations provided give the opportunity for fixing the new reactions. Another point which arises out of the length of residence is the establishment of physical fitness and the overcoming of fatigue tendency. The sense of fatigue in the neurasthenic is partly physical and partly psychical, whatever its primary origin may be. There is constantly great loss of weight, not the loss of a few pounds, but often of stones. Gradually increasing physical effort, after the psychic factors are cleared up, seems to have the greatest effect in increasing the weight, and outside occupation is the best form of exercise for this purpose. The psychic sense of fatigue will be cured by

the special psychotherapeutic measures adopted, *plus* re-education against fatigue.* It is, however, necessary that the patient be sufficiently fit physically, on leaving hospital, to carry on his work without real physical fatigue, as otherwise a grave risk is run that his sensations may lead to re-establishment of the psychic asthenia. This training to physical fitness might seem to be outside the province of the military hospital, but, in my experience, it constitutes the final stage of treatment, just as mobilization of a joint and the strengthening of the muscles which move it constitute the final work of the surgeon who has dealt with the injury.

In this branch of medicine, as in others, the larger issues are obvious, whilst the less obtrusive are missed or taken for granted. In the consulting-room readjustments and adaptations may seem to be satisfactory, but it is in the common reactions of everyday life that the real test lies. The advantage of medical officers living with patients, as in many officers' hospitals, consists largely in the opportunities for seeing these reactions, and a game of golf or cards will often reveal errors of adjustment, or control, that would otherwise pass unnoticed. In a hospital for men this is not such an easy matter, but every opportunity should be available for unobtrusive observation whilst the patient is on occupation or in the day-room.

From this brief indication of the possibilities of institutional management in the war neuroses, it might appear that the neurasthenic was allowed but little rest. This, however, should not be the case, and there must be no routine of occupation or employment, but every patient must be treated as a case apart, and in no sense as a cog in an institutional machine.

A few special features and difficulties in the hospital economy may briefly be mentioned.

In arranging for the institutional treatment of war

* As Déjérine puts it: "Re-education without drawing attention to it" should be our constant aim.

neuroses, no real division need be made into classes, and exceptional cases should simply be treated *secundum artem*. On broad lines patients may be divided into two groups :

- (1) Those suffering from anxiety-states; and
- (2) Those with functional physical disabilities, such as paralyses and contractures.

This division is largely artificial, as many of the latter group also show the anxiety-state in varying degree, and the two groups need not be separated in hospital.

A country situation is certainly best for the hospital, not alone on the grounds of health—though this is of considerable importance—but also for the greater and more varied scope it gives for physical recreation and occupational treatment; moreover, much greater liberty can be allowed than in a city hospital, *freedom from restraint* being regarded as an important element in treatment. Ideally, the hospital should be built in blocks or wards of about fifty beds, each block being, for the purposes of treatment and staffing, a unit with its own medical officer. Good dining-rooms and plenty of recreation-rooms are essential, as the social side of the hospital is an important link in the chain of treatment.

Nursing presents a difficult problem because, from the trained hospital nurse's point of view, there is little opportunity for the exercise of her skill apart from the few cases of intercurrent illness, and an occasional patient undergoing a rest cure. At the same time, a considerable part of the social aspect of re-education will be lost if there are no women in the hospital at all, and the only possible way of including women's society yet devised is by means of the nursing staff. If the right sort of woman can be got to take up the work from this standpoint, well and good, but it is seldom that the well-trained nurse will sacrifice her general training. There would seem, therefore, at present to be only two alternatives: either to be content with a few well-trained nurses for general illness, or

to select nurses for social qualities rather than for certificates and for tact rather than technique. The special nurse will doubtless ultimately be evolved.

Discipline has, of course, to be maintained in a military hospital, and the neurasthenic hospital is no exception, but the special circumstances must be remembered. Patients are "nervy" and irritable, and a fair number are so just because they have failed to adapt themselves to army discipline. It is indeed remarkable that so many have succeeded in doing so, considering the age and the civilian circumstances of a large proportion prior to enlistment. If the patients are to be discharged from the army the question of discipline is not so difficult, but if they are to go back on leaving hospital they must remain soldiers for the sake of the army, and for their own sakes, for experience shows that readjustment after relaxation of discipline is more difficult than the primary adaptation. The gist of the matter is to avoid irritating details, whilst maintaining all disciplinary essentials, and—most difficult of all—to make and meet exceptions, so that the soldier is not unfitted by his stay in hospital for returning to his unit.

Acute and special cases have been omitted from this paper, as these seldom reached the military neurasthenic hospital in this country, and their treatment in any case would be individual. In civil practice, however, special arrangements would be made in the institution for dealing adequately with them during the acute stage. It is impossible here to do more than state that special rooms would be set aside for these cases where isolation, special nursing, continuous baths, or other necessary treatment could be administered.

CHAPTER XI

THE MANAGEMENT OF THE NEUROTIC— INDIVIDUAL

BY MILLAIS CULPIN, M.D., F.R.C.S.

Captain (Temporary) R.A.M.C., Clinical Psychologist, Ewell War Hospital.

INDIRECT CONTROL.

Attitude of physician depends on : (1) nature of case ; (2) method of cure—Analysis of type. Difficulty of strict diagnostic classification.

1. *Hysteria.*

Every hysteria should be curable by mental analysis, but majority require only rapid diagnosis. This treatment has advantage of arresting deception or further developments—Advisability of rough psychological investigation in all cases—All gross physical manifestations should be dealt with at onset.

(a) *Surgical Hysteria.*

Importance of firmness, decision, avoiding irritability—Rapid cure by immediate arrest desirable—Treatment should be private, but atmosphere and influence of cured patients may remove symptoms—Importance of care after symptoms have been removed : (1) they may recur ; (2) frequently hysteria is an excrescence upon an underlying psychasthenia ; (3) anxiety state may follow removal of protective symptoms.

(b) *Unemotional Hysteria.*

Judgment in recognizing type necessary—Modified Weir Mitchell treatment inculcates desire for cure.

2. *Acknowledged Psychasthenia.*

Treatment depends on symptoms :

(a) If patient intelligent, symptoms due to war experience :
(1) ignore them, attack underlying cause ; (2) use symptoms as means of approaching repressed memory, their disappearance as an indication that cause has been found.

(b) If symptoms a recurrence or exaggeration of pre-war trouble, remove them by persuasion, suggestion, or re-education.

3. *Anxiety States.*

Establishment of confidence :

Patient tends to : (1) Avoid talking of symptoms ; (2) cloak real troubles in physical ailments—Physician must show : (1) More open sympathy ; (2) that the real troubles are taken seriously ; (3) encouragement, sometimes suggest symptoms—It is essential that patient understand : (1) Nature of disease ; (2) attitude of physician—Difficulty of confidence in long-standing cases—Treatment without exhaustive analysis should be given trial.

HANDLING OF FAILURES.

1. Physician should recognize reality of symptoms but encourage patient to withstand them.
2. Successes in spite of difficulties demonstrated.
3. Benefit derived from temporary discipline.

DIRECT CONTROL.

It should be based on friendly relationship and confidence—Element of irritability :

- (a) Patient should be given an appreciation of problem ; discipline made secondary.
- (b) Quarrels between patients adjusted on grounds of mutual difficulty.
- (c) Avoidance of any antagonistic element.
- (d) A single impulsive non-dangerous outbreak should not convict patient of lunacy.

Dietary concessions and the use of drugs avoided—Insomnia carefully ascertained, and when it interferes with treatment hypnosis may be used.

WORK AND RECREATION.

Not direct instruments of treatment—Valuable in convalescence—Training in useful pursuits may be used : (1) To stimulate interest ; (2) as a gauge of progress. They become dangerous when : (1) Aids to repression ; (2) employed without ultimate aim.

THE attitude of the medical officer or practitioner to the patient is important, and depends upon the nature of the case and the method one decides to adopt in dealing with it. For this reason it is well to open an interview by taking down a rough outline of the life-history of the patient, his age, civil state and occupation, date of enlistment, war service, previous breakdowns, and family history. This gives a fair idea of the type of case to be dealt with, and meanwhile the manner of the next procedure is decided,

for even the elucidation of symptoms must differ according to the kind of patient. I can draw no hard and fast diagnostic lines, but from the point of view of practical management regard the psychoneuroses as a series beginning at the clear-cut hysterias, passing to the anxiety-states with or without hysterical symptoms, and at the end reaching the deep-rooted—some would say the congenital—psychasthenias; this series being linked on in places to feeble-mindedness, epilepsy, dementia præcox, and melancholic states.

Every hysteria should be curable by mental analysis, but the majority, if taken early, call for no such deep search for causes, and a quick removal of symptoms should be one's aim. It has been my lot to see in the army a large number of functional cases at or soon after their first admission to hospital from local units, and I soon found it was a mistake to place the man in such a position that recovery might be taken by his fellows as evidence of "swinging it." For this reason I either took the man into a small room or, what was simpler, made my diagnosis, and then, with the assurance that only certainty of diagnosis could give, said to him quietly but ungrammatically: "There are two people who know what is the matter with you, one is you and the other is me. We'll let it stop at that. I'll give you a day or so here and then send you back to duty." This was usually sufficient to check the symptoms, but further knowledge makes me uncertain as to the absolute wisdom of my procedure. I cannot say whether these men were early hysterics or conscious deceivers, or whether they were afterwards of any use to the army; my present opinion is that, although I saved a good many men from developing hysterical conditions, yet a rough psychological investigation of all these cases would have eliminated many who, useless as soldiers, have by now drifted into the category of "war neuroses."

When doing surgical work in France I received into my wards a fair number of functional cases from the line,

and recognized that my previous methods were not applicable, but I made it a rule not to evacuate a man before removing all gross manifestations of hysteria. Though my views as a surgeon have been altered by subsequent experience as a psychotherapist, yet I still feel strongly that, apart maybe from so-called shell-shock, the physical symptoms of hysteria can and should be arrested at their onset by whosoever is in charge of the patient. Certainty of diagnosis is essential, but if the frequency of functional disorders is appreciated their recognition becomes easier. Functional contractures and paralyses after slight wounds should never occur if movement is insisted upon at the first opportunity and the use of sticks and crutches is limited to actual necessity. The cure of aphonia presented no difficulty to me in my surgical days, for I soon found that no examination of the throat was necessary in the case of a healthy-looking young man with a whispering voice; a cough assisted by a pat on the back was enough to produce full phonation. But when a case reaches the psychotherapist cure has often become a difficult undertaking, and I have more than once failed to restore phonation until I have put the patient through the processes of revival and abreaction.

The method of dealing with what may be called surgical hysterias depends upon the inclination of the operator; though firmness and decision have their place, any display of irritability must be avoided. If it is decided to obtain a rapid cure of the symptoms, the result should be obtained at one sitting or the difficulties of the case are increased. Although I have said above that the arrest of symptoms at their origin is the duty of all of us, yet I think that, if a practitioner unaccustomed to treatment of these conditions makes a diagnosis in a well-established case, he is justified in making no attempt at treatment and referring the patient to someone familiar with the work. In this event he is well-advised to say nothing about his views to the patient, so as to leave a virgin field for the psychotherapist.

The patient is generally suspicious of being regarded as a malingerer, and if this feeling is not avoided then recovery is opposed by his self-respect. I think this desire, conscious or unconscious, to retain self-respect partly explains the success of dramatic methods of treatment which provide the needful opportunities for recovery.

Nevertheless, the first man to make a diagnosis in a long-standing case has a great advantage; a rapid judgment, followed by a "frontal attack," so takes the patient by surprise that he lets go of his symptoms before his resistance comes into play.

It is essential that treatment should not be carried out in presence of other patients, though in an institution where a wholesome atmosphere prevails the influence of a few cured patients sometimes removes symptoms before the intervention of the medical officer. When the symptoms are apparently removed the man should be watched for a while so that one can judge whether further treatment is necessary. As my experience has increased I have come to regard this as important; the symptoms may recur under slight emotion or fresh ones take the place of those removed, and it is common enough to find that the hysteria is only an excrescence upon an underlying psychasthenia which requires treatment, or that an anxiety-state follows the removal of the protective symptoms. Contrary to the methods of some psychotherapists, I encourage the man to tell me any fresh symptoms, believing that it is better to give him the chance to develop them whilst under observation than to let them appear when he has passed out of my control. The desire to return home and the belief that he will be "all right in civil life" lead a man to minimize his symptoms, and following up my cases after discharge has taught me that expressions of well-being are not always confirmed by the subsequent progress of the patient.

There is a definite type of case characterized by an absence of emotion; the man does not worry about his

symptoms, seeming content to carry them with him for ever, whilst desire for cure is not powerful and there is present a recognizable resistance to treatment; here a modified Weir Mitchell treatment has its use in stimulating a desire for cure, but judgment is necessary in recognizing the type. I have a vivid recollection of a good soldier who had received three months' strict but unsuccessful treatment for a paraplegia which disappeared when certain horrible experiences were brought to light.

Passing from this type we reach cases in which the man is willing to recognize the psychical nature of his troubles, and we have to decide whether to remove symptoms by persuasion, suggestion, or re-education, and then treat further if necessary, or whether to ignore the symptoms and attack the underlying cause at once. A great deal depends upon the patient; if he is intelligent and the symptoms have followed, and are probably due to, war experience, I favour the latter course, and it has the advantage—if one's methods lie that way—of enabling one to use the symptoms as a means of approaching the repressed memory, and their disappearance as an indication that the cause has been found. If the symptoms are, as often happens, a recurrence or exaggeration of pre-war troubles, such a procedure, though full of interest, is so much more difficult and the chance of failure so much greater that persuasion and suggestion may properly be employed.

As we pass from the purely hysterical end of the scale towards the anxiety-states with their depressions, their phobias and obsessions, a more openly sympathetic attitude is necessary. The straight-out hysteric flaunts his symptoms, he is quite pleased to tell about them, and the more he is examined the better he likes it, but the patient suffering from anxiety symptoms tends to keep them to himself. He may, however, translate them into physical complaints, and I suspect that in many cases this is almost a conscious process to account to the doctor for his being

ill, for I find that as soon as he is encouraged to speak of the anxiety symptoms he drops the physical ones.

A man may describe at the first interview a variety of aches and pains, but when he realizes that the real troubles are taken seriously the former drop out of the picture. I frequently ask if he has ever told of them before, and find that he has kept to himself, for months or years, all kinds of fears and anxieties. At one time I was afraid of "suggesting" such symptoms, and adopted circumlocutory methods in arriving at, say, the very common fear of the dark, but I now have no hesitation in putting leading questions. A common dialogue is this: "Do you feel cheerful?" "Yes, pretty cheerful." "The same every day?" "Well, some days I feel a bit bad." "Then tell me how you feel on a bad day." This gives a lead, and the real symptoms are described. When I recognize an anxiety-state, in a man with a sound history, as due to experiences in warfare, I have no hesitation in giving confident assurance of a cure.

Whatever line of treatment is next adopted, it is necessary that the man should now understand the nature of his disease and the attitude of the physician. It is useful to ask what he thinks is the cause of his symptoms. Only rarely does he indicate that they are due to the emotional experiences through which he has passed, his answer nearly always expressing a belief in an anatomical cause. This must be explained away, and at the end of the explanation the man begins to show restlessness in anticipation of being told there is nothing wrong with him. At this stage my talk is generally as follows: "So you see your body and brain and nerves are as healthy as mine, and perhaps you think that I am going to say there is nothing the matter with you. But there is something the matter with you, or you wouldn't be sent to me. You have just told me how you feel, and these feelings are real enough to you, as real as the toothache, and we have to get rid of them somehow."

By all means encourage the man to carry on in spite of his feelings, for you may fail to cure them, but do not let him think that you regard them as trivial and unimportant. If you do he will place you in the same category as the other doctors who have failed to relieve him.

All this should establish the necessary confidence, but I have often been surprised to hear, after many interviews, of some obsession or fear which the patient has hitherto kept hidden from me. One man, after prolonged treatment, owned up to an obsessional desire to strangle anyone to whom he was talking, and admitted that he had kept it hidden lest he should be treated as insane. Sometimes the symptom is only spoken of after it has disappeared, but it is obvious that, if an attempt at mental analysis is to succeed, the patient's fullest confidence must be secured.

The fear of insanity is one of the things a man keeps to himself, and I never hesitate to ask about it. Thoughts of suicide must be brought up for examination and freely discussed: unfortunately, there is a feeling among those officially responsible for the patients that if a man admits to having such thoughts he must be regarded as actually suicidal and be dealt with accordingly. This point of view must be resisted, or the recovery of many men will be seriously hindered; if we are to restrain all psychoneurotics who admit to thoughts of self-destruction our asylums will need enlargement, for if restraint is used at all it must be effective. I meet a few patients who have been shut up in "mental wards" in home hospitals, and they speak quite earnestly about the effect it had upon them.

The confident manner which is such a help in the handling of hysterical subjects is, for me at any rate, not so easily maintained in the face of patients presenting a history of symptoms dating back to a period long before the war. Too often the question arises whether any treatment should be attempted, and one answers

that treatment, to be successful, should have been at least pre-natal. Restoration to the pre-war condition is not too idealistic an aim in most cases, and an intelligent man desirous of cure may often, without exhaustive analysis, be relieved of troubles dating back to infancy, so that it is well to give his treatment a trial.

The handling of our failures is perhaps as important as our methods of cure; recognition of the reality of the symptoms and encouragement to withstand them are necessary in handling those psychasthenics with a well-developed "sentiment d'incomplétude": they should be shown their successes and taught that, in spite of their feelings, they are able to perform their necessary tasks as well as their neighbours. The invertebrate, complaining that he "suffered from nervous debility" all his life, and often showing a strong "mother complex," may benefit from more vigorous urging; a plain intimation that he will be sent home when he shows that he can work will effect at least a temporary improvement. But there will remain cases of the work-shy, others bordering on the feeble-minded, and those hopeless people who seem born without any desire to help themselves or to co-operate in efforts to aid them; these we can only send home in the hope that the State will recognize its obligation to them in some way other than by the grant of a war pension.

There is not much to be said as to the management of cases apart from the personal relationship of patient and physician. Control of the patient should, as far as possible, depend upon the feeling that the medical officer is doing his best for him, and that if friendly relations are disturbed the patient is bound to suffer.

An ever-recurring source of trouble in management is the irritability of which so many patients complain. They often have sufficient introspection to recognize their condition as a part of the illness, and will spontaneously recount instances of loss of temper which they say are quite foreign to their previous dispositions. To meet such a

symptom by purely disciplinary measures is obviously an unsound procedure, though if a man tends to let his instinct of pugnacity have free and unrestrained expression it is well to point out in a quiet talk that whilst no one wishes to annoy him, yet, in the general interest, peace must be maintained, and if he disturbs that peace he will necessarily meet restraint. When a penalty is inevitable, it is best that it should be imposed by someone other than the medical attendant, who should, however, first talk to the man and try to make him regard the punishment as not dictated by personal feeling; it is possible to obtain by this means all the social benefit of punishment without arousing fresh truculence.

Quarrels between patients are usually easy to settle; each antagonist will readily admit his own irritability, and when he is told that the other man is in a similar condition a mutual understanding is not difficult.

It should not be necessary to point out the need of avoiding anything that stirs up this psychologically inadequate emotion of anger, and if one finds that a particular attendant or N.C.O. stimulates this emotion action should be taken.

Apart from definite lunacy it is this irritability which is most likely to involve contact with the law, for it sometimes becomes impulsive, and the question of how to deal with the man is then important. A single impulsive outbreak, if not of a dangerous type, and if followed by a correct introspection, should not, in my opinion, cause the patient to be treated as a criminal or a lunatic. It is only when the safety of others is definitely compromised that the cure of the patient must become a subordinate interest.

Dietary concessions are often sought at the commencement of treatment, but should be avoided, especially in the too common cases of "gastritis." It must be remembered that even during treatment there is a constant tendency to seek refuge in bodily symptoms, and that this

tendency is a manifestation of the unconscious resistance to a real understanding by the patient of his condition. Therefore ordinary medical treatment of subjective ailments must be undertaken with great diagnostic caution.

Drugs should have no part in psychotherapeutics: tonics are unnecessary, the virtue of valerian is a superstition, a placebo is anathema, and the use of bromides not only rests upon heresy, but is physically and mentally harmful. Even aperients must be allowed sparingly, for constipation is a part of the disease, and disappears with the other symptoms.

A history of insomnia must not be accepted without corroboration, but I find my only use for hypnotism as a temporary palliative for those patients who have not slept for many nights, and who for that reason cannot give the attention necessary for treatment; in such cases hypnosis is easy and effective.

Work and recreation I regard not as direct instruments of treatment, but as useful means of helping any convalescent man to feel that he is becoming capable of taking his part in the world again. To use work as a means of "occupying the mind" sounds attractive, but the man who works at a hard mechanical task all day long generally owns up in the end that he has done it to keep himself from thinking of his memories or unpleasant feelings. Therefore I am always watchful in such cases that the man does not defeat me by hiding his symptoms and claiming to have recovered: I have seen one hard worker of this type whom I regarded as cured when he was fighting the most horrible war memories, and his promotion to easier work was followed by a relapse.

I discourage the usual ward employments of embroidery and mat-making, as these blind-alley occupations serve no good purpose whatever and are used to help bury symptoms which should be dealt with by other means. I regard this point in management as very important and

likely to be overlooked. The same objections do not apply to the training or education of the man in useful pursuits, which serves not as a deadening agent, but as a stimulation, and at the same time provides a useful gauge of his progress towards active citizenship.

Unfortunately, it is difficult to prevent the "hospitalization" of the sick soldier, whether his disease be organic or functional. The histories of our patients abound in records of long periods of hospital life, often under diagnoses which veiled the real condition. Most of us have felt at times that the less we do the less we want to do, and it is our task to undo the effect of the long spells of organized inactivity which tend in all patients to destroy energy and initiative, and are especially harmful in psychoneurotics. This should be the purpose of both work and recreation, but to employ either as a means of choking down symptoms which can be removed by a rational psychotherapy is a misdirected effort.

SUMMARY

CHAPTER XII

SUMMARY

BY WILLIAM McDougall, M.B., D.Sc., F.R.S.

*Late Major (Temporary) R.A.M.C., Senior Medical Officer, Ashurst
War Hospital for Neurological Cases.*

IN the foregoing chapters of this book the several writers have presented, each from his own point of view and in the light of his own experience in the cases of soldiers suffering from neuroses, that extension of understanding and interest in the neuroses which, it may be hoped, is one of the permanent benefits brought by the war.

It is the inevitable consequence of the present very imperfect understanding of these conditions that the several writers are not in entire agreement with one another. It is clear to the attentive reader that, even where they use the same technical terms, they in many cases attach different meanings to these terms, and that, in their conceptions of the causation and in their principles of treatment of these functional nervous disorders, they are not entirely consistent one with another. The Editor and his contributors have felt that these divergencies of view should not be concealed from the reader; that this method of independent presentation of the several main topics by as many independent writers gives a truer and more useful picture of the present state of knowledge than the more consistent but necessarily one-sided exposition that might be achieved by a single hand. As a partial remedy for the inevitable drawbacks of this method, the Editor has invited me to attempt to summarize, to bring

to a focus, and as far as possible to harmonize, the substance of the several contributions, in this final chapter. This is a difficult and invidious task, and my first words must be of apology to each and all of the writers for whatever in this chapter may seem to derogate from the authority and the value of the views expressed by them.

Wide as are the differences of opinion and practice expressed or implied by the writers, there is nevertheless much that is common to them all. Let us see what are these main points of agreement. All are agreed that, although physical strain and shock have played a considerable part in the production of some cases of war neurosis, mental disturbance of some sort is the more important condition of the onset, and largely determines the nature of the symptoms in the great majority of cases.

Dr. Crichton Miller recognizes the occurrence of a certain number of cases of pure "shell-shock," in the sense of cases presenting symptoms of nervous disorder (without physical signs of organic nervous disease) which seem to result directly from the physical action of concussion, whether acting directly upon the central nervous system or through the medium of the circulatory or other systems. If we recognize such cases, then I think we must admit, more explicitly than Dr. Crichton Miller has done, the probability that an element of such physical concussion enters into a large number of military cases in varying degrees, as it certainly does into most of those cases of neurosis which follow upon gunshot wounds of the head.

A second way, also generally recognized, in which the physical enters into the causation of neurosis, is by the predisposing effect of physical fatigue or exhaustion resulting from prolonged bodily and mental strain, especially if this involves deprivation of sleep over a considerable period.

A third way is the disturbance of the endocrinal secretions. It is true that such disturbances, as also the loss of sleep which conduces to exhaustion, may be due to

mental influences in many cases ; but it remains probable that, in other cases, they are caused primarily by physical conditions.

A fourth class of physical agents conducing to neurosis are the poisons (poison gas, syphilis, the toxins of malaria, dysentery, influenza, etc.) which, disordering the actions of the heart, lungs, bowel, and other viscera, cause feelings of weakness and inefficiency.

It may be doubted whether these or any other physical influences could of themselves produce, in a man otherwise in good bodily and mental health and of good constitution, a condition which could properly be diagnosed as a neurosis. But any departure from bodily health may, by inducing anxiety in the mind of the patient, especially perhaps a secret, unexpressed or even subconscious anxiety, favour the onset of neurosis.

On the other hand, it may equally be doubted whether, in a man in perfect physical condition and of good constitution, any of the mental disturbances, conflicts, or disharmonies, which play so great a part in inducing neurosis, could of themselves bring about this result, if they did not in some degree, by deprivation of rest, disturbance of circulation or some other bodily function, evoke the co-operation of bodily factors.

In all this question of the bodily and mental factors in causation there is, I think, no fundamental disagreement between the writers. They differ merely in regard to the degree of importance they would attach to these respectively, and the degree of therapeutic attention to be paid to them. The main thing in this connection is to realize the intimate and constant action and reaction between mind and body, and their reciprocal dependence for all healthy living. For the physician, like every other person practically concerned with human beings, is compelled to accept the notion of interaction between mind and body as at least an indispensable hypothesis, no matter what his taste in metaphysics may be.

In the same way the writers are, I think, agreed in recognizing that, though congenitally and developmentally unstable persons are much more liable to neurosis than the normally healthy, yet any man of the most normal constitution and healthy development may, under sufficiently prolonged and severe strain of his bodily and mental constitution, become neurotic. To admit this is to repudiate the view, dogmatically held in some quarters, that the origin of a neurosis is always to be traced back to some error of development in childhood. In other words, the teaching of this book is not Freudian, it does not require readers either to pervert wholly the meaning of the words sex and sexual, or to see the origin of neurosis in a very hypothetical sexuality of infancy. To say this is not to deny that many of the writers have accepted and made use of some of the valuable conceptions which we owe largely to Professor Freud, notably the conceptions of repression, regression, unconscious mental conflict, and complexes.

At the same time it may be pointed out that some of them use a terminology which perhaps may seem to imply the acceptance of more of Freudian doctrines than they actually express; such terms as "mental mechanism" where mental process is meant, "transference" to denote the setting of the patient in a relation of confidence and goodwill towards his physician; Dr. Crichton Miller's use of the terms "homosexual" and "mother-complex," and the term "psycho-analysis" itself; all these give a Freudian flavour to some of the essays which might mislead the hasty reader. Let us remember that every relation between two persons is between persons of either the same or the opposite sex, and is therefore in this sense either homo- or hetero-sexual. This incontestable fact should neither startle us nor betray us, by way of an elementary logical fallacy, into accepting the view that all human relations are sexual in the sense that the sexual instinct is concerned in them.

Another point of agreement is that the mental processes which produce and maintain neurotic symptoms are not always such that the patient can, with the best will to do so, give any account of them; in other words, these processes are largely "unconscious." With the use of this word we are at once upon very difficult and slippery ground. The word has been used in so many different senses, and connected with so many speculative notions, that it is perhaps desirable to repudiate every other use but that in which it stands simply to exclude clear awareness; especially is it unnecessary to write the word with a capital letter, and to regard it as standing for some mystical all-powerful entity. It is impossible to deal with cases of neuroses without soon being brought to infer the reality of processes which resemble conscious mental processes in every way except that the patient can give no account of them. How these processes should be regarded, whether as unconscious physical, as purely physiological or nervous, as subconscious or co-conscious, or as all these in turn—these are questions of the deepest theoretical interest, but of little practical importance to the clinician. For him the important thing is to understand the part they play in producing and maintaining neurosis, and to recognize the evidences of their operation. This he cannot hope to do without such guidance as is afforded in the foregoing chapters; for the discovery of these principles has been one of the most difficult achievements of modern science to which many brilliant intellects have contributed. The difficulty that most men find in accepting the notion of unconscious mental processes may be softened for the reader if he will reflect that much of his normal mental life is only very partially expressed in consciousness, that he often is unaware of the motives of his own deliberate actions, and can recollect nothing of many past experiences which have contributed to shape his tastes, his moral and intellectual principles, his ideals, his character, and his motives. And he must recognize

that, when we use for the description of unconscious mental processes the terms in which we are accustomed to describe our conscious mental life, we take a certain liberty justified by the lack of any other terminology. When, for example, Dr. Prideaux says that every hysterical symptom has its unconscious motive, he means that it is the outcome of a teleological or purposive activity which implies and depends upon the recognition of the patient's circumstances and the way in which they will be affected by the symptom; as when a "shell-shocked" soldier becomes paraplegic or mute during his recovery from the first acute symptoms, the appearance of this disability is dependent upon his knowledge that such a disability will render him unfit to return to the line, and also upon the working within him of the impulse of fear; and yet the patient is honestly ignorant of this connection between his conscious knowledge and his symptoms, and may honestly protest that he has no fear of returning to the front.

But, though all the writers recognize the importance of unconscious mental processes in the neuroses, they do so with different degrees of emphasis. Dr. Rivers, for example, regards "repression" as essentially a conscious activity, and he is probably right in supposing that conscious repression may and often does play an important part. Yet others see good reason to believe that repression is in many cases wholly or largely an unconscious operation, both in banishing past experience from memory, and in resisting the normal tendencies of associative reproduction and of voluntary efforts of recollection to bring it back to consciousness. But, whether the process of "repression" be more or less conscious, its evil consequences seem to follow in so far as it succeeds in producing amnesia for the painful or distressing experience. It seems probable that underlying every neurosis is some amnesia; it may be the forgetting of the use of one or more limbs, or of the sensitivity of some region of the body, or of the movements

of articulation or phonation, or of some large tract of experience, or the forgetting of all particular facts, even the most intimate personal facts such as the soldier's name, number, regiment, his wife and family and home ; in such cases the amnesia is the leading symptom and can hardly be overlooked ; and in extreme cases, which are generally described as cases of regression, the amnesia may involve practically the patient's whole stock of acquired skill and knowledge, so that he is temporarily reduced to an infantile state both in bodily and mental respects, an infantility which may, as in a recent case of my own, even involve his digestive apparatus, so that he can digest nothing but milk and slops. In other cases the amnesia may affect only some particular incident, some momentary terror, some flash of thought, or purpose, or desire. In many such cases it can only be discovered, if at all, by careful search.

The amnesia may be of all degrees of completeness, ranging from a mere aversion from the recollection of the incident or other content, a difficulty in bringing the mind to contemplate it, as in Dr. Rivers' instances of conscious repression, to a degree which defies the utmost combined efforts of the physician and his patient. This wide use of the term amnesia, to cover all grades, from the slightest cases of partial repression to the most complete, is, I think, abundantly justified ; not only because the cases form a series continuously graded in degree of completeness, in which it is impossible to draw any sharp dividing-line ; but also because the slighter and the more pronounced degrees of amnesia are alike in the nature of the mental and bodily disturbances in which they play the essential part, and in the essential principles of the treatment which they demand for their relief—namely, the bringing into clear consciousness and a readjustment of the attitude of the patient to the content of the amnesia.

A word may be said about the genuineness of the amnesia. When in the foregoing paragraph the reader came upon a reference to the utmost but unavailing efforts

of the patient to recover his lost memories, he may well have felt a little sceptical as to the genuineness of these efforts. No observation and no reasoning can absolutely establish the genuineness of any particular case of amnesia, and only experience of many cases can by accumulation of moral probabilities and improbabilities, and by the revelation of a conformity to type and empirical rule, establish the genuineness or reality of these amnesias. The fact that there is so often, especially in military cases, an obvious or possible motive for the amnesia goes far to account for the resolute scepticism with which they are too often regarded by the layman or regimental medical officer. It may be well, therefore, to illustrate the type of case in which the moral evidence seems very strong.

Sergeant B. was a man of excellent character and very fair education and intelligence. While on service in France he learnt that his wife was guilty of an infidelity of a peculiarly reprehensible kind. He obtained leave, came home, investigated the facts, and put in hand proceedings for divorce; and while on leave, considering himself virtually a free man, he renewed an attachment which had been broken off through misunderstanding some time before his marriage. This marriage he had contracted in a mood of reckless and quixotic generosity, but of very little affection, in the period of reaction following upon this estrangement.

Some months after returning to duty at the front he suffered "shell-shock." During a disastrous bombardment of his unit, a shell exploded close to him. He did not wholly lose consciousness, but was obviously disordered in conduct and strange in speech. He was shortly sent home, and came under my care a few hours after landing in England. He was to all appearances a normal man, except that he could tell me nothing of his life and experiences between a moment some months before the outbreak of war, when he had a slight fall, and his setting foot on the quay as he landed from the hospital ship a

few hours before. He expressed himself entirely ignorant of the war, and was astonished at finding himself in khaki. But of all his life previous to the amnesic period he conversed frankly and intelligently. The complicated course of his domestic relations and the history of his military service was gradually revealed to him by letters and personal interviews with friends and relatives. He renewed his affectionate relations with the young lady to whom he had been at one time engaged, and, when informed of the renewal of their engagement, he accepted it. When informed of the death of his younger brother at the front during the early months of the war, a brother to whom he was much attached, he was overcome with grief. He was keenly desirous of divorce and of marriage with his first and only love, his only scruple arising from the existence of his stepchild, for whom he retained a strong affection. The one barrier to his divorce was his complete amnesia for all the incidents on which his application must be based. If he could have overcome this, his way would have lain plain before him. He was conscious of no aversion from further service, for he had long been a keen volunteer and territorial soldier, and he had no conscious recollection of the horrors of the battle-field.

Every device was used to restore his memory, including visits to his home and to scenery he had known during his training for active service, and the reading of detailed letters from the front which he had sent home before his "shell-shock." But nothing availed. His case was explained to him at great length, and he took a very intelligent interest in it. He passed readily into deep hypnosis, and in that condition related many details of his life which in the waking state he seemed to have forgotten; but, with the exception of a few vivid pictures of his surroundings on the hospital ship which brought him to England, nothing of the amnesic period could be recovered. Always, and many times, when in hypnosis I pushed him hard, insisting upon his recollection, my hold

upon him was suddenly resolved when the critical point of his narrative was reached, the hypnosis terminated, and he woke to normal consciousness and independence. This last feature of the case, which was very striking, is, as Captain Hadfield has pointed out, not very uncommon. It indicates unmistakably that the amnesia depended not upon a mere dissociation, but upon a continued and ever watchful activity of repression, a repressing activity strong enough to defy the ascendancy which I had acquired in the hypnotic state, as well as the strong desire of the patient to overcome it in order to be fit for divorce and remarriage, and to feel himself again in normal health. For in addition to the amnesia, he suffered from severe headaches and a lassitude which contrasted strongly with his former independent and self-reliant character. Here, then, was a case in which all conscious motives, the strength and reality of which can hardly be doubted, prompted in vain the effort to recollect. The repressing forces prevailed over them and over every artifice by which I sought to evade or overcome them.*

Another point in respect of which some scepticism may be felt is the influence of the will, or desire, impulse, intention, or more generally of conation, upon recollection. Most of us are inclined to a fatalistic attitude towards our memory ; either it works or it does not work, and in the second case we feel all we can do is to wait until it happens to work and give us back the lost idea. We incline to regard it as a very independent and uncertain tempered servant to whom we venture only to proffer some deferential suggestion when we want something done. The undue stress laid by so many psychologists on the place of association in the mind, and the many descriptions of the working of associative reproduction which imply that it

* The subsequent history is that, some months after return to his civil occupation, when he had recently met and conversed with comrades from the front whom he had known also in civil life, I succeeded in hypnosis in reviving in full dramatic form the whole of the lost memories.

is little more than the mechanical spreading of nervous excitation from one nerve cell to another, according to the state of their nervous connections, these things also have tended to obscure the rôle of conation in memory. In fact, in the general neglect of the facts of conation by both the common mind and the majority of psychologists, the memory has suffered more such neglect, amounting well-nigh to total ignoring, than any other class of mental operation. Yet we all in some degree recognize our power of voluntary recollection, and make occasional efforts of recollection with more or less success. The success with which in hypnosis the patient may be induced to recall apparently forgotten contents of his memory is at once evidence that the operator works upon his patient by calling into play one or more of his conative tendencies (a fact revealed in almost every feature of the relation between the patient and the operator), and also evidence of the far-reaching power within the province of memory of well-focussed conation.

The following case illustrates this power in a striking manner. A Canadian soldier came under my care within a short time of leaving the battle-field with an extensive amnesia. He had vague memories of his life in France, and he remembered that his home was a farm in Canada and some general facts about Canada. He vaguely thought he was married, and that he was fond of his wife; for he had found in his pocket a photograph of a young woman, and, when he looked at it, he wanted very much to see her; and he supposed this was a photograph of his wife. Interrogation failed to recover the memories of the onset of his trouble or of his home life, and in hypnosis (repeated several times) I succeeded only in obtaining a few vivid scenes in which he vividly pictured himself in France or accompanied by his wife in places he failed to recognize. He suffered from general lassitude and feeling of weakness and restlessness.

He came to me one day, about a month after admission,

when we were both feeling discouraged by our lack of success, and asked, "Is it absolutely necessary to remember all these things you ask me about? Isn't it possible to get well without that? I would prefer not to remember being in the trenches." I assured him emphatically that it was absolutely necessary to remember, that he would not get well without doing so, that he must remember and firmly resolve to do so. This conversation took place in the grounds of the hospital. Returning past the same spot after ten minutes, I found him awaiting me in a state of joyful excitement. He felt that he had recovered all his lost memories, and poured out a mass of detailed description of the horrors he had witnessed at the front and then of his home life, fitting in the detached scenes of his hypnotic states. It appeared that my few words had spurred him to a more whole-hearted effort of recollection, or perhaps we should say, more accurately, had tipped the balance between the conative forces making for recollection and those making for repression, in favour of the former. Interesting physical evidence of the restored unity of control of the conative forces that came with the relief of the amnesia was afforded by this patient's dynamometer record. Up to the time of the sudden recovery he had never been able to force the index beyond the 30-kilo mark. Tested within an hour of his recovery of memory, he squeezed it to the 90-kilo mark.

It remains an open question whether amnesia is always the result of purposive repression, whether it may not sometimes rather result from what may be called a physiological accident which produces a state of simple dissociation.

But however produced, and however maintained, whether as a positive dissociation or by an active and continued repression, and whatever its extent, some amnesia seems to be an important factor in all true neurosis. For it is the amnesia which (1) either constitutes the neurosis, as in the cases of simple hysterical disabilities,

in which, the dissociation being completed, the rest of the mind remains comparatively calm and untroubled in its mutilated condition; or (2) underlies the continued conflict which wears out the strength of the patient suffering from anxiety neurosis; or (3) operating at times independently and dominating the whole personality with some emotion and impulse, throws the patient into epileptic fits, or fugues, or somnambulism, or dramatic rehearsals of past incidents.

For, with the doubtful exception of the cases of the first of these three classes, the amnesic content of the mind does not simply lie quiescent. Even in the first class it may reveal a continuous activity by maintaining a spasm or tremor of the muscles of the paralysed limb, or some tic or repeated involuntary movement. In the other cases the emotional and impulsive tendencies of the repressed memory or complex seem to be constantly seeking to express themselves and to be kept in restraint only by an exhausting expenditure of repressing energy, a restraint from which they partially escape during sleep; or in the third class of cases, they reveal themselves in sudden outbreaks during waking life which banish normal consciousness and behaviour for longer or shorter periods.

And, so long as any amnesia exists, it would seem that the patient remains liable to disturbances of these kinds, together with headache, giddiness, feelings of lassitude and lack of confidence, insomnia, or other secondary symptoms which seem to be the consequence of the conflict between the repressed energies of the complex and the repressing energies of the rest of the personality.

Hence the importance for treatment of seeking the amnesia, of discovering it in its full extent as completely as possible, and of joining up its content with the rest of the memory continuum. For it is through the intellectual aspect of mental content, through the cognitive parts of the manifold mental disposition which enter into the structure of the mind, that the syntæsis and control of

the impulses and emotions is affected. Amnesia, whether repressive or purely dissociative, seems to be the expression of solution of functional continuity between the cognitive dispositions; and functional continuity of all cognitive dispositions is the essential condition of that synthetic activity which makes of the normal mind, with all its diverse and divergent conative tendencies, a harmonious unity.

It is perhaps useful to put this in physiological terms as definitely as our ignorance of the nervous system will allow. The conative emotional dispositions which are the springs of all our impulses, of the energy which we expend in thinking, feeling, doing, lie in the basal part of the brain. They are functionally isolated from one another, and act in relative independence of and opposition to one another, except in so far as the development of the cerebrum, the material basis of our higher cognitive life, with its wealth of interrelating and co-ordinating apparatus, renders them all subservient to, and harmonious members of, one common system, in which the activity of each conative disposition is constantly controlled and co-ordinated by the influence of the whole system. In the amnesia, some part of the cognitive apparatus of the upper brain becomes functionally discontinuous with the rest, and, retaining its connections with one or more of the conative dispositions in the base of the brain, leads a relatively independent life, withdrawn from the control of the whole system.

The importance of the complete discovery of amnesia may be illustrated by the following case. XY suffered "shell-shock" near Arras in 1917, and, after a period in hospital and convalescent camp, returned to his battalion shortly before the Cambrai affair in November of that year. During the retreat he was buried by shell explosion, and sent, mute and paraplegic, to a well-known "neurasthenic" hospital. There, according to the practice of that hospital, his speech and power of walking were speedily

restored by the methods of forcible "persuasion" for which it is justly famed. But he continued to suffer almost daily functional fits of a mild kind, in which he lost all sense of his surroundings. After some twelve months' residence in that hospital he was discharged to civil life, and was able for a time to resume work, though still suffering frequent "fits." Some weeks after his return to light civil occupation, he was set to rather more strenuous and trying work; whereupon his "fits" assumed a severer type, and he came under my care as a pensioner in a very miserable condition, hardly able to use his legs, and with coarse general tremor. It then appeared that he could remember nothing of his experiences between rejoining his battalion and a moment some seven months later, when he suddenly "woke up" in a field near the hospital of which he had been an inmate for some six months. He asked a girl whom he saw in the field to tell him where he was, and was surprised to hear that he was in England; when led back to the hospital, he remembered nothing of his arrival and subsequent stay in that place, and so continued working on the farm until his discharge six months later. Close interrogation failed to relieve the main amnesia, covering the period of seven months between rejoining his battalion and "coming to himself" in the English field; but it led to greater clearness of recollection of his first "shell-shock" period, and his control of his limbs improved, though he continued to suffer occasional "fits." Exploration under hypnosis was then tried, but on several occasions with only partial success. He remembered in detail the retreat up to the point at which he was buried; but from that point his recollection repeatedly leapt forward to the "coming to himself" in the field seven months later. However, perseverance and variation of method succeeded in getting him to recall in detail the events of this period, even his thoughts and feelings while he lay buried and while he was being dug out. After this his improvement was rapid.

He lost his tremors, suffered no recurrence of "fits," and seemed to be cured.

This case illustrates very well the inadequacy of the relief of such bodily symptoms as paraplegia and mutism. In some cases these or other similar bodily symptoms seem to constitute the whole of the amnesia, and in such cases their relief suffices to cure the patient, or at least to restore him to capacity for ordinary civil life. But in many cases they are only a part of the amnesia, often, as in this case, a part of minor importance.

It may be asked, Does the mere recollection of the lapsed memories suffice to cure? To this the answer seems to be: No; the mere recollection in itself does nothing. The essential step is the linking up of these recollections (or of the corresponding cognitive dispositions) with the rest of the mind, so that they are restored to their normal place and relations in the total system, and thereby become amenable to the control of the reason and the will. This is the most essential step in treatment, as shown by two facts: (1) In many of these cases it is possible to show that the "fits" are periods in which the amnesic contents return to consciousness, excluding all other mental activity; (2) mere recall in hypnosis effects no cure, unless and until the patient is enabled to recollect the forgotten content in his normal waking condition.

When this has been accomplished, the patient may need further help in readjusting his attitude to the recovered content, but in many cases, especially among the war neuroses, the patient can achieve this with little or no further help.

The great part played by amnesia in neurosis gives great scope for the use of hypnosis, or what Captain Hadfield proposes to call "hypno-analysis." For, it is generally admitted, even by the many practitioners who for a variety of reasons are prejudiced against it, that in hypnosis, whether of a deeper or a lighter so-called hypnoidal degree, the overcoming of amnesia is greatly

facilitated. The more elaborate processes of "psycho-analysis" proper consist essentially of the same two steps, namely: (1) The relief of amnesia, the rendering the patient clearly aware of those contents of the mind which are out of harmony with the whole; (2) the readjustment of his attitude towards these contents. "Psycho-analysis," as commonly understood, implies that these procedures are undertaken by a physician who accepts a mass of highly speculative doctrine emanating from Vienna; and, since the founder and followers of this school have an indisputable claim to this term, it is only fair and expedient to avoid the use of it where it is not intended to imply the acceptance of these esoteric doctrines. Nor does the term imply the double nature or indicate the two essential steps of all psychotherapeutics, namely *mental exploration* and *mental readjustment*, but accentuates unduly the former of these steps. The opposite fault may be found in terms advocated in other quarters to denote the true method of psychotherapy—namely, persuasion, suggestion, re-education; they point only to the second step. In actual practice most of the advocates of each of these methods probably combine them with the others to some extent; for there is nothing essentially incompatible in the various methods, if they are intelligently applied; yet many of them are no doubt inclined to neglect in greater or less degree the former step, the process of exploration or, if you will, analysis, and so to ignore the more or less unconscious and even conscious factors of the psychogenetic process, the readjustment of which is the essential second step.

The teaching of this book may be summarized concisely as follows. The psycho-neuroses result from disharmony in the mind; this disharmony frequently leads to amnesia of some kind and degree, the sinking or pushing away from the control of the personality of some part of the mental content. The first essential step in psychotherapy is the exploration of the patient's mind, in order

to reveal his personal character and the impressions, thoughts, feelings, and impulses, which have played a part in the genesis of the disorder, and also to establish relations of sympathy and confidence. Skilfully conducted conversation may suffice in many cases; but, since some of the factors are commonly unconscious in some degree on their first operation, or have been subsequently forgotten and remain hidden from the patient's unaided introspection, by reason of dissociation or continued repression, it is often necessary to employ special methods of exploration. Of these methods hypno-analysis, free association, and the association-reaction, are the chief. The content of dreams may often be usefully explored and examined by these methods.

The psychogenetic factors having been discovered as fully as possible, the second step, readjustment, must be made. If the circumstances are favourable—e.g., in the case of war neuroses, if the war is over and the patient's future and present circumstances are conceived by him in a way which is satisfactory to him—he may effect their adjustment unaided. In other cases he may need much or little help in this task, and then persuasion, suggestion, rational re-education, occupational training, and what Captain Hadfield describes as reassociation, and Dr. Bernard Hart* has elsewhere called “affective therapeutics,” must be used in whatever combination may commend itself to the physician's judgment.

* “The Methods of Psychotherapy.” *Proc. Roy. Soc. Med.*, vol. xii, No. 2, 1918.

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